SEPTEMBER • OCTOBER 1965

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

A State Plans for Its Retarded

Giving Babies a Healthy Start

Early Blocks to Learning

Raising Children's Aspirations

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BORN TOO SOON, this underweight baby requires the protection of an incubator, close pediatric observation, and highly skilled nursing attention. Intensive followup of premature infants and efforts to prevent prematurity are characteristics of the maternity and infant care projects described on pages 179–184.

**Leopold Lippman** was with the California Study Commission on Mental Retardation throughout the life of the commission, from October 1963 to last June. Prior to this, he was executive director of the Washington Association for Retarded Children, with headquarters in Seattle. He has handled special health and welfare assignments in California, has served as consultant to other States in mental retardation planning, and was appointed this September to be California's coordinator of mental retardation programs.

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Professor of education and human development at the University of Chicago since 1964, **Robert D. Hess** has been connected with the university's Committee on Human Development since he obtained his doctorate there in 1950. He has also been a visiting lecturer at the University of Kansas City. Before joining the committee's staff, **Virginia Shipman** was an instructor in child and educational psychology at the University of Pittsburgh, where she had received her doctoral degree.

Since he conducted the project described here, **George Henderson** has been appointed assistant director of intercultural relations for the Detroit public schools. He has also received a *Better Homes and Gardens* "Action Award in Education" for the project. Before going to the Detroit Urban League, he was assistant director of the delinquency control center at Wayne State University. For the past 3 years, he has been a part-time sociology instructor there.

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**What are some of the problems involved in planning for the mentally retarded? Asked this question by the editor of CHILDREN when California's comprehensive plan, the first in the Nation, appeared, Mr. Lippman prepared the accompanying article on the California experience. The review of the California report which follows this article is a condensation of a critique requested of Mr. Dybwad by the U.S. Public Health Service.**

# A STATE PLANS FOR ITS MENTALLY RETARDED

LEOPOLD LIPPMAN

*Former Executive Secretary*
*California Study Commission on Mental Retardation*

ON OCTOBER 30, 1963, less than one week after President Kennedy signed Public Law 88–156, which among other provisions encouraged comprehensive State planning in mental retardation,[1] the California Study Commission on Mental Retardation held its first meeting. Fourteen months later, its final report, "The Undeveloped Resource: A Plan for the Mentally Retarded of California," [2] was delivered to Governor Brown and the California Legislature in advance of the 1965 session.

California was able to start and to conclude its comprehensive mental retardation planning 10 to 15 months ahead of the other 53 States and jurisdictions, because the legislature had responded promptly to the challenge of the report of the President's Panel on Mental Retardation, "A Proposed Program for National Action to Combat Mental Retardation," submitted to the President the previous year.[3] The President's Panel on Mental Retardation had rendered its report in October 1962, and in the regular session of 1963 the State legislature had created the study commission, charged it to recommend proposed programs, and directed the submission of a final report by January 1965. The legislature had also appropriated sufficient funds for the commission to start its work, so that it was not necessary to wait for the Federal planning grant due under Public Law 88–156 before getting under way.

As a result of the quick action of the legislature and the Governor in creating the commission, California had the honor to be the first in the Nation to complete its comprehensive mental retardation plan. It also suffered the disadvantages of being first, because it could not profit by the mistakes of others. Nevertheless, its report has received wide and enthusiastic attention. Requests for copies have been received from 30 States.

There were many hurdles in the way of effective planning—semantic, statistical, fiscal, administrative, and political, among others. The commission chairman himself repeatedly expressed the view that the very commission structure was inappropriate to the task. Nevertheless, this was the machinery the legislature had created; these were the individuals the Governor had appointed; and the members of the commission cared enough about the subject to do their best with the assignment.

### *Learning the Facts*

The first problems had to do with facts: How many retarded persons are there in California? What are their needs? What services now exist?

And (as a basis for legislative recommendations) what do the current statutes provide?

The last two questions were the easiest to answer. They required a great deal of careful, painstaking work, the final results of which were neither polished nor wholly satisfactory, because of time and other limitations, but some usable answers were available. To get the facts on present services, the commission created a committee which inquired about programs of State departments and local public and voluntary agencies in 11 counties. The resulting report [4] was published about midway in the commission's work. It proved to be a valuable document.

The matter of existing statutes was a deceptively simple question, because the State's laws go back many decades, provisions affecting the retarded appear in many codes uncoordinated with each other, and terminology varies widely. Nevertheless, a skilled legal researcher, working under the direction of the commission chairman, himself an attorney, produced what has proved to be the first summary collection of statutes on the subject anywhere in the United States.[5] The compendium directed attention not only to the statutes dealing specifically with the retarded, but also to oblique references and even omissions which might affect the rights of the retarded.

It was the first question, however, that was the trickiest. To determine how many mentally retarded persons there are in California, it is necessary to count them. But, dealing with the difficult question of how requires first facing the challenging one: Count whom? Probing this problem revealed a more basic one: To deal realistically with mental retardation, one had to define it. This proved a knotty point throughout the life of the commission.

Prevalence clearly depended on definition. A different concept—even a few words changed—would yield different figures, and thereby a different statement of the extent and nature of the problem. The commission rejected intelligence quotient as the criterion, but even such a simple numerical device poses problems. Should the cutoff point be IQ 70? Or 75? Or 85? The difference in prevalence figures is enormous, especially in the upper ranges—and the nature of the problem changes substantially.

The study commission looked at many different definitions, including the 4-ply criterion index developed in Delaware by Jastak and his colleagues.[6] The commission also reviewed the few community prevalence studies which have been conducted over the years. A highly sophisticated project was under way in Riverside, Calif., under the direction of research workers from Pacific State Hospital, but the results were not available in time for the commission's report.

In the end, after much consultation and thought, the commission accepted the language which had been developed by the American Association on Mental Deficiency: "Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." [7]

This was at least a working definition; but the problem still remained to discover reliable prevalence figures. Despite all available information, including some preliminary data from the Riverside study, the commission found itself short of hard facts. Clearly, it was impossible to survey the actual population of California in the time available. The commission was unwilling to accept the widely used prevalence figure of 3 percent, because the meager evidence available suggested this was too high. Still, it had no reliable substitute.

After considerable research, and much debate within the commission, it was agreed that the prevalence (if not the incidence) of mental retardation varies with age, and that therefore a single percentage figure would not apply. The commission agreed that the prevalence figure might reach 3 percent for school-age children, but that it would be much lower for newborns, rising among preschool children and tapering downward for adults. This concept produced an irregular curve which peaked during the age span 8–16. Included in this concept was the idea that the individual may move in and out of the group called "retarded" in the course of his lifetime, depending on the degree of his handicap in relation to the demands posed by society and the availability of resources to help him become self-sufficient.

### *A Sociological Problem*

Related to questions of definition and prevalence was a sociological problem. Should the culturally disadvantaged be counted among the retarded? Their environmentally caused lag is not the conventional mental deficiency, and yet their performance in school and their potential as adults are distinctly lower than the average among their peers. The commission noted that low income, poor housing, and inferior medical care have marked adverse effects on intellectual development. Therefore, it offered a series of recommendations, including the provision of earlier and more regular prenatal care, direct social services to indigent families and children, re-

## Principles Expressed in the California Report on Mental Retardation

The State of California accepts a responsibility for its mentally retarded citizens. . . .

The Study Commission believes that:

1. **Mental retardation is a social problem.** Every retarded person and his family are entitled to the concern and assistance of the community, expressed through public and voluntary resources. This is their right, as citizens of the United States and of California.

2. Where necessary, **the State must discharge the obligation of society.**

3. **The best hope is prevention,** and it is our responsibility to develop new knowledge through research and to apply it promptly. Meanwhile, we have an obligation to the retarded who are already with us.

4. **There is some potential for growth in every human being.** For each person, society should provide the opportunity to develop to the limits of his capabilities.

5. **Services should be planned and provided as part of a continuum,** which means that the pattern of facilities and eligibility shall be so complete as to meet the needs of each retarded person, regardless of his age or degree of handicap, and at each stage of his life development. . . .

6. Because **the retarded person is a human being first, and a handicapped individual secondarily,** he should have access to all the general community services that he can use in common with others. Only when integrated services fail to meet his needs should there be specialized services.

7. **Services for retarded persons should be close to their homes and families.** . . . Moreover, no retarded person should enter an institution who can be cared for in the community, and no one should remain in an institution who can adjust outside.

8. . . . **Research and professional training are two essential components** of the total program, and a pattern of services is incomplete without them.

9. **Retarded persons, or their families acting in their behalf, should have substantial freedom of choice** among public and private services. This accords with the dignity of the individual and his right of self-determination for his own life.

10. **The State should provide for and encourage creative flexibility** in all programs operating for the mentally retarded in California.

training of adults for new job opportunities, and compensatory education for retarded children coming from disadvantaged homes.

Fortunately, positive efforts were already under way in California to provide compensatory education programs with the use of the Federal support available under the Economic Opportunity Act. The commission's observations were helpful as reinforcement in getting these programs established.

### *Administrative Problems*

Planning had to take place in an administrative and historical context, yet not necessarily accept the existing pattern as best.

In his charge to the commission at its first meeting, the Governor said:

"You are not bound to any past or present pattern of services nor, certainly, of administrative organization."

However, this was easier to say than to observe. Among the general public—and to some extent within the commission—it was assumed that the department which operated the State hospitals had primary and indeed exclusive concern with the mentally retarded. The fact was, of course, that far more retarded children received direct services in public schools throughout the State than in the State hospitals; and beyond this, with the exception of scattered community services supported in part with State funds, such as a few diagnostic clinics and sheltered workshops, there were no public services for the huge majority of California's mentally retarded children. Nevertheless, the stereotyped reaction was: "It's the problem of the Department of Mental Hygiene. Let's leave it there." The commission found it difficult to break through this pattern of thinking and at the same time retain the valuable existing services, the body of professional competence, and the intricate network of human interrelationships which had been built up over the years.

The problem was solved in part, and in some degree unfortunately, by circumstances. During the active life of the commission, three men served successively as directors of the Department of Mental Hygiene. All were first-rate officials who, although actively interested and cooperative, were, for obvious reasons, preoccupied with larger concerns. It was thus difficult to maintain momentum or continuity

in the relationships between the commission and the department. As a result, what might have been an unhealthy domination of the commission by one department became instead a partial vacuum which actually diminished the commission's effectiveness in planning.

There was another aspect to interdepartmental relations as they manifested themselves within the commission. The law specified that the directors of five State departments should be members of the commission. (These were education, mental hygiene, employment, public health, and social welfare. A sixth, rehabilitation, was later added by amendment.) One of these, the superintendent of public instruction, was an independently elected official; the others were appointees of the Governor. Most of the departments represented had pre-existing concern with services for the mentally retarded, in some cases involving budgets of millions of dollars.

Experience with bureaucracy would lead one to expect that under such circumstances there would be a struggle for enlargement of power. In the field of mental retardation, however, it appears that the customary rules do not always apply. Rather than empire building, there seemed to be some tendency to avoid additional responsibility. Departmental spokesmen on occasion would suggest that particular tasks be referred elsewhere. To be sure, these views were expressed from the honest conviction that the proposed services would not fit into the existing pattern, but the effect was to reject new program ideas and leave them in limbo.

The question of each department's role was part of a large challenge the commission faced; How to deal with the power struggle inherent in diverse professional viewpoints and organizational interests?

The Governor settled part of this problem by his selection of persons to be appointed to the commission. For members "representing the general public," he could have selected six persons whose chief qualification was a concern for the civic welfare. He did not do so. Instead, for the most part, he chose persons with substantial involvement, and hence strong convictions, in the field of mental retardation.

The Governor might also have selected persons to represent organizations with a stake in the problem. This again he did not do. His decision created some problems, in that certain organizations felt they had been deliberately omitted and therefore slighted; but it also freed each member of the commission to act from his own convictions rather than as an organizational representative.

Jack Halpin, the commission chairman, and I, as the executive secretary, did feel that the commission would have been stronger if its members had included a designated representative of the largest single interest group, the organized parents of the mentally retarded. Several members of the commission were parents of retarded children, but they were not selected to be organizational representatives. They served as individuals, drawing on their personal as well as their civic experience. (In its recommendations for a permanent planning mechanism, the commission later specified a representative for "the consumer"—by which it meant parents of the retarded, so designated.)

As chairman, the Governor chose a man with training in the law and political science, and with judicial experience. By temperament, the chairman was a forceful individual, intelligent, with a respect for research, and yet one who believed in vigorous action. He was constantly striving for the imaginative approach, the innovation, the creative solution. Some of his proposals startled other members of the commission and the public, but shocked people into thinking for themselves and coming up with workable alternatives.

### *State Responsibility*

A major issue in planning for more effective services to the retarded is whether such services are primarily a State or a local responsibility. This is doubtless being debated in State planning bodies throughout the Nation. In California, there is a special accent on the issue in the impressive growth since 1957 of community mental health services. Under the Short-Doyle Act, the State financially assists local governments in establishing locally controlled mental health programs.

To a considerable extent, the question is part of a larger philosophical and political one, having to do with the appropriate roles of Federal, State, and local governments. The California Study Commission on Mental Retardation confronted the issue directly and answered it forcefully in the opening sentence of its report:[2] "The State of California accepts a responsibility for its mentally retarded citizens."

Despite the vigor of this assertion, there was a marked difference of viewpoint among commission members, some of them contending most earnestly that responsibility and power should rest in the counties and the communities. In its report,[2] the commission did say, repeatedly, that services for the re-

tarded and their families should be close to home, and that communities should take initiative, but it placed final responsibility at the State level.

### *Continuity and Coordination*

Determining the specific services which the State and the communities should make available to the mentally retarded was relatively easy. The guidelines in the work of the National Association for Retarded Children, the President's Panel on Mental Retardation, and other authoritative bodies were clear enough. They simply required adaptation to the peculiarities of California's situation.

Tying these services into a usable package was, however, a more difficult task. From the outset, the commission struggled with the core question of how to effectuate the necessary "continuum of services." How insure that the retarded individual receives what he needs at each stage of his life development? How provide a balanced program of services available to everyone who needs them? How avoid a domination of the service program by one agency, either at the State or the community level? How coordinate service agencies which are essentially independent of each other? And, as important as any question, how incorporate the citizenry into the planning which must go on if services are to change in response to changing needs?

To protect the individual retarded person and assure continuity in his life, the commission recommended establishment of regional diagnostic and counseling centers. The coordinating mechanism was harder to find. The commission's answer was a Mental Retardation Program Board.

Under the commission's proposal, the board would be established by the legislature and its members would be appointed by the Governor, who would also designate the chairman. The board members would include representatives of all State departments having responsibility for services to the retarded; local government units; voluntary organizations; and the "consumers" of services. Responsibilities of the board would include coordination of existing services and stimulation of new programs to meet discerned needs; development and periodic revision of a comprehensive plan for services to the retarded; setting and enforcement of standards for all such services; and leadership liaison with community mental retardation planning bodies. The board would employ an executive secretary but would not operate programs and therefore would not need a large appropriation for its own work. It would exert considerable influence, however, in its review of departmental services and proposals, and in its recommendations to the Governor and the legislature.

The most unusual single feature of the Mental Retardation Program Board, as envisioned by the study commission, was to serve as a contractor in purchasing services for mentally retarded persons. In this role, the board would have fiscal responsibilities and would have the power to assign and reassign programs among departments as part of the continuous planning process. In accordance with the commission's emphasis on the importance of providing a variety of alternatives and on the need for flexibility, the board would have power to enter into contracts with either public or private service agencies at either the State or local level.

The board proposal, the most striking innovation of the commission's work, proved also to be the most controversial. In acting on this recommendation, the legislature made the board advisory only, and stripped away its proposed powers to assign and reassign programs among State departments and to serve as contractor in the purchase of services for the retarded. Instead of an executive secretary to the board, the new legislation provides for a coordinator of mental retardation programs. It does, however, provide that the departments of State government may enter into a joint powers agreement. This provision, which emerged as an amendment to the original bill, may prove to be the vehicle through which more efficient organization of services is achieved.

### *Priorities for Action*

Once the framework and the broad pattern of a comprehensive program are set, how does the planning agency move toward realization of its recommendations? The study commission's expiration date was written into the law which established it in 1963; but from the beginning it was obvious that the recommendations would not be in effect when the commission went out of existence in June 1965.

The commission met this problem with a two-barreled answer. First it recommended establishment of the Mental Retardation Program Board, which would have the ongoing function of planning for the mentally retarded. Then, because the program board could not come into existence until the legislature acted, the commission took upon itself for 1965 the board's function in offering priority recommendations for the legislature's immediate consideration.

For fiscal year 1965–66, therefore, the commission

selected from among its more than 60 recommendations 7 which it considered most needful of attention and action. These included establishment of the diagnostic and counseling centers, development of new types of residential facilities, provision of rehabilitation services, strengthening of special education programs, establishment of development centers for children unable to attend the public schools, and important steps toward professional training and encouragement of research.

To each of these priority recommendations the commission attached the most realistic price tag it could compute. Its report noted that the total cost of the proposed new services in the first year would be less than 4 percent of what the State of California was currently spending for the retarded. The section on priority recommendations concluded:

> **The new approach will open doors for better services, so that California can offer real hope to the mentally retarded and their families. Ultimately, through rehabilitation and through prevention, the State will serve its people better and will reduce the cost. Enlightened, efficient programs for the mentally retarded are sound public economy.**[2]

### *Mobilizing Support*

From the beginning of the commission's work, it was obvious that consensus among the members in developing a comprehensive plan would not be enough. It was necessary to insure acceptance of the recommendations by the Governor and the legislature, or the whole effort would be merely a sterile exercise. Because the commission itself, as a group, had little or no political strength, it had to conduct its work so as to mobilize support along the way. Many of its activities were designed to this end.

At every stage, the commission invited the viewpoints of professional people and interested citizens. There were frequent consultations with administration officials and legislative leaders. All commission meetings were open to the public; in addition, there were two all-day public hearings at which individuals and organizations were encouraged to express their views. The development of a complimentary mailing list, including everyone who asked to be included, led to an active interchange of views between the commission and its constituency.

Finally, after six full-scale meetings and innumerable other discussions, the commission took its tentative conclusions and recommendations to the people of California through regional workshops. The workshops were conducted by the University of California Extension, which arranged for the fullest circulation and discussion of the commission's proposals, in a neutral, dispassionate setting. More than 1,800 persons attended the workshops, held on 6 successive Saturdays in different parts of the State; and their reactions had a significant influence on the commission's final report. The effect was reciprocal, for, as people observed the earnestness and sincerity of the commission, and they saw their ideas being accepted, they were enlisted among the supporters of the commission's program, thereby building up statewide enthusiasm for its recommendations. This was reflected in newspaper, radio, and television coverage, and later in expressions of opinion to the legislators.

At one point in the commission's deliberations—about the time the crucial issues were coming up for decision—the astute chairman asked a question of central importance: Should the commission work toward the development of the "ideal" plan for meeting the needs of the mentally retarded persons of California? Or should it build into its report the compromises and awareness of political realities which would give the proposals a real chance of enactment?

Two members of the commission responded immediately, almost as if by conditioned reflex. One (the mother of a retarded child) said, "Let us state the ideal." The other (a member of the legislature) said, "Let's build the political realities into the report." Consensus seemed to go with the politically sensitive member of the commission, and so—although long-range objectives were stated in the final report—the immediate priorities were keyed to what seemed realistically attainable.

There were legislative obstacles, in some degree peculiar to California, in the year 1965. A knowledgeable observer of legislative trends remarked wryly, early in the session, that although every session was unique, this one was "more unique." In most States, the problem will be different, as the comprehensive mental retardation planning bodies will conclude their work late in 1965 and will then have to wait for the next biennial sessions of their legislatures more than a year later, in 1967. This may result in a cooling-off, or loss of enthusiasm and of popular support. In California, the study commission certainly hit while the iron was hot, bringing in its final report at the beginning of the 1965 session and at a peak of nationwide concern, but it did run into some obstacles not of its own making.

The problem with which the members of the legislature were most concerned in 1965 was reapportionment, which, because of a court order, necessarily occupied the central attention of most of the legislators in the first months of the year. This had nothing

at all to do with mental retardation, and yet the effect on the commission's program was substantial and for the most part destructive. The other big problems which impinged on the mental retardation proposals were the size of the total State budget and the need for new taxes; and while these are perennial, they seemed to be especially acute this year. The study commission could do nothing about any of these large problems—nothing but wait, and try to build public support, and hope.

In the end, the legislature enacted every bill put before it as a direct result of the commission's work. Some of the measures were diluted, and the funds available proved to be less than the commission thought necessary, but at least the principles now stand in the law. To this extent, California has taken substantial steps toward meeting its obligations as an affluent State in serving its less fortunate members. Those recommendations of the California Study Commission on Mental Retardation which are still unrealized now stand as a challenge to future sessions of the legislature.

[1] Lesser, Arthur J.: Accent on prevention through improved service. *Children*, January–February 1964.

[2] California Study Commission on Mental Retardation: The undeveloped resource: a plan for the mentally retarded of California. Report to the Governor and the Legislature. Sacramento. January 1965.

[3] U.S. Department of Health, Education, and Welfare, The President's Panel on Mental Retardation: A proposed program for national action to combat mental retardation; a report to the President. October 1962.

[4] California Study Commission on Mental Retardation: Report of survey by committee on existing resources, functions, and coverage. Sacramento. June 1964.

[5] ———: Mental retardation and the law: a survey of California laws affecting the mentally retarded. Sacramento. July 1964.

[6] Jastak, Joseph F.; MacPhee, Halsey M.; Whiteman, Martin: Mental retardation: its nature and incidence. University Publishers, New York. 1963.

[7] Heber, Rick: A manual on terminology and classification in mental retardation. *American Journal of Mental Deficiency* (monograph supplement, 2d edition), 1961.

# A Critique of California's Report on Mental Retardation

GUNNAR DYBWAD

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*International Union for Child Welfare, Geneva*

*THE Undeveloped Resource: A Plan for the Mentally Retarded of California*, the report of California's Study Commission on Mental Retardation, deserves the attention of mental retardation planners in other States. The report shows the evidence of extensive interdisciplinary and interagency work, and its first major recommendation tries to safeguard this broad comprehensive approach for the future in calling for the establishment, by statute, of a Mental Retardation Program Board, whose members would be appointed by the Governor.

The recommendations soundly specify that the board should have the power to employ staff and so be administratively independent of existing State departments, but that it will not operate any service programs. It would have sufficient powers for effective coordination, including the annual revision of a plan for coordination to be submitted to the California legislature and the Governor as a basis for legislative and administrative changes.

Serious questions, however, must be raised with regard to the recommendation that the program board be invested with powers in regard to "program assignments and reassignments . . . the power to determine the agency which must accept prime responsibility for the provision of a particular service," since this would clearly be a prerogative of the legislature. Furthermore, a recommendation that the board ". . . serve as a contractor in purchasing services for mentally retarded persons" would strongly impede its function as an impartial coordinating body, as it would then compete with the operating State agencies for legislative appropriations. In any case, it is more than likely that the legislature will balk at giving such broad powers to a coordinating body. [And, as the preceding article points out, the 1965 California Legislature did balk at granting the board any of these powers. Ed.]

The study commission also recommended establishing 10 or more regional diagnostic and counseling centers to facilitate casefinding and early diagnosis, stating that such a center need not consist of a single facility or a group of physical structures, but could

consist of a group of services. Significantly, the commission recommended that these centers are to be a responsibility of the State Department of Public Health, rather than of the Department of Mental Hygiene.

While recognizing California's long-established national leadership in special education, the commission called not only for strengthening the existing public school program for "educable" and "trainable" children, but also for extending public schooling for the retarded downward into nursery school, and upward into adult education. (In fact, California already had 26 classes for retarded adults in 1963.) Unfortunately, the report does not make reference to the urgent need for public school classes for the multiply handicapped retarded child.

One area that continues to receive far too little attention, both on Federal and State levels, is the importance of public welfare services in planning for mentally retarded adults. It is therefore most gratifying that the commission's report calls in several places for wider use of public assistance grants and for broadening of State and Federal statutory provisions in this regard. It stresses the importance not only of making sure that special attention be paid to the needs of retarded children in the program of aid to families with dependent children but also of focusing on the help that can be given to retarded parents to improve their ability to maintain a family home.

The commission emphasized two other specific service areas: cooperative programs between the State Departments of Social Welfare and of Rehabilitation for the development of sheltered workshops for the retarded (already under way in California), and the use of public welfare funds to develop group residences for retarded adults.

### *Residential Facilities*

The report makes some intriguing recommendations which deviate considerably from viewpoints formerly held by the California Department of Mental Hygiene, one of the first to designate all its mental retardation institutions as "hospitals." It takes the view that the State hospitals for the mentally retarded should be used only for retarded persons needing hospitalization, "with medical, surgical or psychiatric problems of such scope or intensity as to require care in a licensed hospital, with nursing and medical care prescribed by the patient's physician, and usually requiring considerable professional nursing care."

The report, however, recognizes that some individuals needing such hospitalization might be cared for in local pediatric or general hospitals or "*nursing homes susceptible of conversion from their present programs.*" It needs to be emphasized that the commission, by adding this last phrase (italicized by the reviewer), recognized the undesirability of placing mentally retarded persons into existing nursing homes specifically designed for and experienced in the care of geriatric patients.

On the other hand, the report calls for a wide variety of other programs to provide nonmedical residential care, such as foster homes, including 5-day week arrangements for children who must attend school away from home, community living arrangements for young retarded adults who are working, regional residential centers, and other arrangements. The commission wisely refrained from proposing wholesale removal of residents of existing overcrowded institutions for the retarded to proprietary or county owned nursing homes. Rather, it makes the following pointed observation:

> **At this stage (1964), it is still not clear what types of physical facilities and what program services may be best for each retarded person needing residential care. Moreover, it is not yet possible to tell, even in broad statistical terms, what the need is for each type of facility. Program planning should therefore allow for—indeed, should encourage—experimentation with different types of care, organization and financing.**

Regrettably, the report fails to point up the need for the Department of Mental Hygiene to give leadership in stimulating the development of facilities for providing psychiatric counseling and treatment for mentally retarded adults who live in the community.

It is not possible to deal in this space with the many other significant recommendations of the study commission, such as those for public guardianship, home nursing and homemaker services, centers for premature babies, genetic counseling services, and registers of "high-risk" babies. Emphasis is given to community planning and the role of private agencies, voluntary membership organizations, and the churches. The need for financing improved and increased training for professional workers is stressed throughout, and a special section points up the tasks this represents for California's higher education system. Considerable space is given to highlighting the need for research relating to prevention.

In spite of its few shortcomings, the report is a valuable addition to the resources for mental retardation planning.

*Some ways that maternity and infant care projects are . . .*

# GIVING BABIES A HEALTHY START IN LIFE

KATHRYN CLOSE

*AS I SEE IT, our major contribution is giving babies of disadvantaged families a healthy start in life. This will not cure poverty, but it is a necessary first step in this direction.*

The speaker was a Minneapolis obstetrician who works one day a week in a maternity clinic in a neighborhood where incomes have been identified as among the lowest in the city, and rates of birth, prematurity, and infant deaths the highest. He recognized that being born to uneducated, unskilled, and bewildered poverty-stricken parents could in itself be a major handicap for even the healthiest of babies, but he saw their first hope in a healthy birth and the next in education—especially for the parents. "And here," he said enthusiastically, referring to the work of the clinic's nurses, nutritionist, and social worker, "we are making a real beginning."

In this city, the establishment of three maternity clinics by the health department within the past year has been a definite break with tradition. So, too, are the use of a nutritionist and a social worker in the public health setting. The innovations have come about as part of the health department's federally aided maternity and infant care project which got under way in January 1965. Already the project's staff cites numerous instances in which the clinic team has brought about correction of conditions dangerous to the future of an unborn child—conditions which might have remained undetected if the existence of the clinics had not encouraged the mothers to seek early prenatal care.

The project is one of 25 maternity and infant care projects which thus far (mid-July 1965) have been approved by the Children's Bureau for Federal aid under the 1963 Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act.[1] Plans for seven others are pending approval. With the exception of a few which are State-administered, the projects are administered by local health departments. They all have the same aim: to improve the health of expectant mothers, reduce infant deaths, and try to prevent mental retardation and other defects in children by providing high-quality comprehensive maternity care, with special emphasis on women in high risk of suffering a pregnancy casualty, and followup care for infants in high risk of developing handicaps. The focus is on mothers and infants in low-income areas where the incidence of births, prematurity, and infant deaths is high.[1]

Only 11 of the projects have been in operation for more than 6 months. By their very nature they are "reaching out" projects, and while the extent of their reach varies, there is abundant evidence that they have achieved a marked improvement not only in the ease with which pregnant women in areas of poverty can secure maternity services but also in the quality of services available to them and their babies.

For example, 10 rural counties in Georgia, where obstetrical service to the very poor has consisted chiefly of delivery by a granny midwife, are now sending about 600 "high-risk" pregnant women a

**DISCRIMINATION PROHIBITED**—Title VI of the Civil Rights Act of 1964 states: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance." Therefore, the maternity and infant care projects approved by the Children's Bureau for Federal aid under the Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act, like every program or activity receiving financial assistance from the Department of Health, Education, and Welfare, must be operated in compliance with this law.

year to a university teaching hospital in Augusta for complete obstetrical care—prenatal, delivery, and post partum.

In Baltimore, Md., all pregnant women not under the care of private physicians are urged to come to a central maternity center for an initial examination by an obstetrician, laboratory tests, a dental examination, and enrollment in an appropriate maternity service. For high-risk patients this may be in one of the city's five district health clinics with delivery at the city hospital, or in one of four teaching hospitals under contract to provide project patients with complete maternity service. Dental care is provided when indicated.

In Chicago, project-paid staff additions to the city's maternity clinics have helped upgrade the clinics' services and extend their hours; arrangements with 12 teaching hospitals are sparing high-risk obstetrical patients the impersonal treatment of an overcrowded county hospital; and 4 project-established pediatric clinics are providing intensive medical supervision of high-risk babies.

In Detroit, 3 voluntary hospitals, under contract to provide comprehensive maternity service to 3,300 high-risk patients a year, have relieved the load on the health department's only maternity clinic, so its patients can now receive more attention; and home visits to maternity patients and newborns have been increased through a contract with a voluntary visiting nursing service.

The list could continue, with many more examples than there are projects, for, in addition to seeing that high-quality medical and laboratory services are available to pregnant women in low-income areas, the projects are providing a variety of services to help such women seek prenatal care early and regularly in pregnancy, and to provide adequate care for their babies after birth.

Basic requirements are set by the law and by Children's Bureau standards for assuring quality of service. Thus a project's medical arrangements must provide for comprehensiveness, quality and continuity of care, during the prenatal, labor, and post-partum periods; all applying pregnant women living in a project area must be accepted for prenatal care, but only "high-risk mothers" of low-income families may have their hospital bills paid by project funds; the locality must put up 25 percent of the total project cost. Since comprehensiveness is interpreted to mean taking into account all the social and health factors relating to the well-being of the expectant mother and her child, comprehensive care is expected to include the services of obstetricians, pediatricians, public health nurses, social workers, nutritionists, laboratory technicians, and clerical and other auxiliary personnel.

Physical conditions, age ranges, and social circumstances associated with a high rate of pregnancy casualty and prematurity are the determinants of a high-risk pregnancy and thus may include: toxemia of pregnancy, hemorrhage; dystocia (difficult labor); concurrent medical problems, such as anemia, diabetes, or infections; multiple pregnancy; a history of difficulties in previous pregnancies, in either mother or child; pregnancy in women under 16 or over 40; out-of-wedlock pregnancy. "High-risk babies" may be babies born to "high-risk mothers" or babies in their first year with adverse physical conditions associated with birth.

In spite of basic similarities, each project has a distinct character, shaped by its community's special needs, resources, and problems, and the special enthusiasms of its planners and staff. This is reflected in its emphasis and reach and in the relative measures of frustration and hope in the staff's outlook. Thus in one community where resources for prenatal care were already fairly well-established, a major effort is spent on making their services and their importance known to the women needing them; in another, the stress is on the provision of new neighborhood clinics; in still another, parent education is strongly emphasized.

### *Casefinding and Keeping*

Behind the creation of the maternity and infant care program were figures showing a high incidence among indigent populations of births in which the mother received little or no prenatal care, and a high association between the lack of prenatal care and unfortunate pregnancy outcome. There have been

arguments over whether the failure to receive prenatal care lay in the mothers' failure to understand its importance or in the inaccessibility and nature of the facilities offered. The projects tend to tackle the problem from both points of view.

Take, for example, the Baltimore project, where early casefinding is a major goal, but keeping women coming regularly for care is recognized as having something to do with the way services are offered. There, the project in establishing its central intake maternity center paid special attention to appearance and comfort, with the aim of putting the new patient immediately at ease. Gaily colored couches and comfortable chairs are arranged in informal groupings in a large waiting room. Food-vending machines line the wall, along with literature racks containing simple pamphlets on prenatal and baby care. A fenced-in play area equipped with toys, and sometimes with a volunteer "play lady," is available for children. While the district health clinics are less spacious, for the most part they also have a comfortable appearance.

In order to get women to the maternity center early in pregnancy, a social worker and a health educator are working closely together to reach them through established community agencies, schools, civic groups, churches, and block organizations, and through their neighborhood contacts, confidants, and leaders—the beauticians of small hairdressing shops, insurance collectors who call at the home for the weekly premium on a burial policy, ministers of storefront gospel churches, attendants at laundromats. Many of these neighborhood contacts not only pass out the project's literature (soon to include a comic book on prenatal care), but also talk directly to women about the importance of early prenatal care.

Similar reaching-out efforts in Chicago are made through public housing projects, the neighborhood centers of the local antipoverty program, and, among other organizations, those which make special efforts to welcome newcomers to the city—such as a lay Catholic sisterhood and a new resident's committee of a club federation.

In Minneapolis, the clinics stagger their appointments to prevent the long waits which are so often a discouraging aspect of clinic attendance.

For women who for valid reasons cannot make it to the clinic on their own, city projects will pay taxi costs, as they do for transportation to hospitals for delivery or in another emergency. In rural areas, however, other arrangements have been necessary. In Augusta, Ga., for example, where project patients come from as far as 80 miles away, the project has arranged with morticians to transport patients by car or ambulance to and from the hospital for their clinic visits and at time of delivery. To cut down on the chances of births in transit, the project has also established a boarding home in Augusta where patients who are "easy deliverers" can stay when they are approaching term.

This project is now considering the possibility of retraining some of the granny midwives who have been put out of business by its services, as homemakers to help out families while mothers are hospitalized and when they bring their babies home.

### *Parent Education*

Many people hope that the projects will have a lasting effect in raising the general level of health and child-care practices among the women served. Because of the staff expansion, clinical personnel have more time to explain things to patients and to counsel with them. In addition, nurses, nutritionists, social workers, and health educators are carrying on parent discussion groups, some sporadically, others in a planned, continuous program.

In the hospital-centered project in Augusta, Ga., for example, a maternity nurse whose chief function is parent education is experimenting in the use of closed circuit television to get her message through to expectant and new mothers and to teach other members of the staff the kinds of things that women with little educational background and few resources need to know to prepare for and to take care of a baby. In a series of video tapes, which she and the project's co-director made themselves, she demonstrates in simple fashion how to bathe the baby, what to eat, how to prepare the baby's formula, how to care for oneself in the post-partum period, and how to prepare a layette with available materials—for example, making diapers out of flour sacks and a bassinet out of a cardboard box.

Using the TV showings as a springboard in discussion groups with both inpatients and outpatients, she finds an excellent attention-getter: "When they see me on television, and standing there, a real person, they become fascinated." She is hoping to make a tape on sex education, particularly for the very young pregnant girls who "don't even realize what has happened to them."

This project, like many others, includes aid in family planning as an integral part of its medical care. "And almost everyone who is told about it wants it,"

is the report. Such aid, however, is given only to mothers who ask for it after being informed of its availability.

In Baltimore, a volunteer from the local Planned Parenthood Association mans a booth in a prominent spot at the central intake maternity center and gives information on the various types of methods and materials available. Patients are told they may receive instructions and supplies at their post-partum visit if they so request, and about two-thirds of the mothers have done so. Post-partum visits are scheduled for 4 weeks after delivery, for experience has shown that often after that it is too late to prevent another pregnancy.

### *Continuity of Care*

Continuity of care is approached in different ways in different areas. The ideal—for the mother to have the same doctor for prenatal, delivery, and post-partum care—is rarely achieved, even for those patients who receive comprehensive care through a contracting teaching hospital, since there is usually division between outpatient and inpatient hospital staff. But a degree of continuity is provided in all projects. In smaller projects, as in Minneapolis where the three maternity clinics have only one physician apiece, the expectant mother does have the same physician for her full prenatal and post-partum care. But in other areas, where maternity clinics have large part-time staffs of physicians, some working only a few hours a week, this goal is not always achieved. The public health nurse, who works both in the clinic and out in the neighborhood, then becomes the thread of continuity.

Careful transmission of records from clinic to hospital and back provides another thread; and in some areas a project nurse is located in the hospital of delivery who sees that the records of high-risk patients are called to the attention of the attending physician.

In Baltimore, the project has placed two professional nurse-midwives on the staff of district health clinics to give complete prenatal and post-partum care to patients having no complications. Unlike the physicians, the nurse-midwives work in the clinics on a full-time basis, and so are able to see the same patients at every visit. Their patients have had an above-average record of clinic attendance. On a few occasions, public health nurses have arranged for these nurse-midwives to go into a home to examine a pregnant woman too frightened to attend the clinic. The very "laying on of hands" in these instances, it is said, produced enough confidence in the women to bring them into the clinic.

The generalized public health nurse is recognized as a key figure in any maternal and child health nursing program; hence the provision of additional nurses for public health units or districts has been an important aspect of most maternity and infant care projects. It is the public health nurse who interviews the expectant or new mother at the clinic to be sure that doctor's orders are understood; who visits the home of every registered high-risk patient to learn about conditions there; who follows up on broken clinic appointments; who visits mother and child after their return from the hospital; who gives the mother instructions in the care of herself and her baby; and who calls the social worker's attention to crises or conditions needing social intervention. In addition, through her neighborhood rounds, she is a major casefinder for the maternity clinics.

### *High-Risk Babies*

Babies born of high-risk mothers are usually examined by pediatricians while still in the hospital, and the circumstances of the birth—such as a child's critically long failure to breathe—or any obvious or suspicious problems are reported to a special followup clinic or the health department's regular well-child clinics. Premature babies are kept in the hospital of birth or at a "premature center" until large enough to be taken home safely.

Only a few projects have thus far established special pediatric clinics for high-risk infants. In Chicago, four such clinics provide complete pediatric examination and treatment and, when needed, the service of specialist consultants for all babies born prematurely, all babies born of high-risk mothers, and all babies with birth defects or other conditions obstructive of healthy development. The clinicians are given frequent opportunities to improve their techniques, as in a recent demonstration of a new method of testing infants' hearing.

When a baby's condition in followup is diagnosed as "failure to thrive"—as with an infant who weighed 5 pounds at birth and 4 pounds at 7 weeks—the baby is hospitalized and a public health nurse asked to make an immediate home visit to assess the situation. The nurse and a teaching homemaker sent in by the social worker may be enough to improve the mother's ability to provide appropriate child care. If abuse is suspected the case is referred to the court or to a protective agency.

Far more common, however, are the babies who

thrive under their mothers' care because incipient problems were discovered and treated early—the child whose kidney was removed at 5 weeks when a massive growth was discovered; another whose infantile hernia was corrected by surgery; three babies whose eyesight has been saved because in followup eye discharges were noted, examined, and treated.

### *Some Problems*

Problems faced by the projects are both common and distinctive. A common one is staffing, but its seriousness depends a great deal on the community's customary salary levels. For example, a project in a large city accustomed to meeting physicians' salary expectations has had little difficulty finding pediatricians to staff its infant clinics; but the same project, faced with a failure of the public services to recognize the profession of social work, has thus far been unable to get salaries approved by the city authorities that would attract professional social workers. In another city, with higher social work salaries, the project had only a little trouble filling its complement of four social work positions. And still another project, in a region of low salary levels, finds itself caught in the necessity of competing nationally for highly qualified paramedical personnel and the impossibility of offering a salary above the State's rate.

Another common problem, frustrating in some measure to all the projects, but far more serious in some areas than others, is the inadequacy of community resources to ward off latent human tragedies. What can a social worker do to help a victim of incest if the only response of welfare and court officials in the rural area covered by the project is a shrugging reference to "these people" and "the way they live"? What can a doctor provide that will keep a baby healthy who, because of community indifference, has to be taken home to live with 17 other people in 2 rooms furnished with 2 beds? (Or, in less extreme instances, to a household of 8 people in 2 rooms, 13 people in 4 rooms, or 10 people in 3 rooms?) Or how can the nutritionist help a pregnant mother, with four children at home, to raise the level of her nutrition, if her public assistance allowance provides for only 21 cents a meal per person in a city where food costs are high? Or what can be done when a hospital requests removal of a baby abandoned by his mother and the local social agencies insist there are no more foster homes or adoptive homes available?

Where community resources are woefully inadequate, the project's social workers tend to become community organizers seeking out potentialities for promoting services and organizing or joining committees focused on specific needs—such as schooling for the teenage unmarried mother, or the promotion of adoption services for Negro babies. Where community resources are more adequate, the social workers serve as catalysts in bringing need and resource together—occasionally even to the point of personally conducting a bewildered woman to an appropriate social agency. There have also been occasions when the social worker has used his status as a representative of the local board of health to make it possible for families to move from unspeakable housing into better quarters.

More typical, however, are the cooperative arrangements made by projects with local welfare departments. In Baltimore, for example, if home visits have revealed conditions considered detrimental to a newborn, the project will continue to pay for the baby's care in the hospital until the welfare department has made more suitable arrangements.

In Chicago, the welfare department has recruited and trained 10 homemakers for the project. These are assigned by the project social worker to families in emergency need—for example, the family in which a working father, a "high-risk" infant, and his 3-year-old brother were deserted by the mother 4 weeks after her confinement. Most often, however, the homemakers are used for teaching housekeeping and baby care to mothers returning with newborns to badly disorganized households.

**Long and tiresome waits, on not too comfortable chairs, as in this picture, have long been the rule in many clinics. Now efforts are being made to shorten waits, through staggered appointments, and to supply more comfortable chairs.**

In Minneapolis, all unmarried mothers are referred to the welfare department, which provides them with a special program of casework and other assistance, regardless of legal residence.

In other areas, however, the problem of pregnancy out of wedlock exists in more overwhelming proportions. In Chicago, for example, so many unmarried pregnant women and girls are seen in the health department's maternity clinics that the maternity and infant care project only classifies them as "high risk" if they have physical complications or are in a high-risk age group—over 40 or under 16. The under-16's alone—some in their second pregnancy—present an enormous problem because of the paucity of community resources to help pregnant girls from indigent families prepare for their future and the future of their babies. The project's social worker—so far the only one it has—is working with community groups toward the establishment of a casework and educational program for such girls, and is herself providing as much casework treatment as her organizational responsibilities will allow.

In Baltimore, the chief social worker talks with every unmarried pregnant girl under 17 who comes into the maternity center. He may refer her to the welfare department's child welfare division for protective service, to a voluntary agency for shelter care, or to a hospital for inclusion in a group therapy experiment with pregnant teenagers; or he may himself work with the girl and her parents as they plan for her own and her baby's future.

Problems requiring the social workers' attention are of course not confined to the unmarried. A 34-year-old mother with 11 children, who has not been out of her own yard for 2 years and has never been on a bus, has to be helped to get up the courage to take the trip to the clinic; a young victim of rubella has to be helped to face her firstborn's serious deformity; a pregnant mother of three who has left her abusive alcoholic husband needs help in planning for the future; a nonresident couple, with a premature baby still in the hospital, needs help in finding a way to ward off an impending eviction.

Among the most frequent medical problems encountered in the clinics are anemia and toxemia. Nutritionists report that these conditions are almost invariably related to faulty eating habits, stemming partly from an inability to stretch a meagre food allowance and partly from food preferences which run to an overabundance of starches and sugar—perhaps because of their filling quality. Anemia is also a problem in some high-risk babies.

To counteract the problem of anemia some projects supply iron pills to nearly all prenatal patients; and the doctors in high-risk baby clinics tend to prescribe formulas containing iron. At the same time, to bring about salutary and lasting changes in food habits, the nutritionists work through the nurses, through direct counseling with the expectant mothers, through demonstrations of how to prepare nutritious low-cost foods palatably, through the preparation of attractive nutritional materials, and through talks to community groups. Achieving such change, nutritionists report, is especially difficult with teenagers, particularly those pregnant with their second or third child who are "just too discouraged to care whether they lose weight or not."

### *What It Means*

The maternity and infant care program is, of course, essentially a medical program and as such cannot be expected to cure all the ills that accompany poverty. What it does for people, rather than what it cannot do, is what counts. In Chicago, for example, a mother who in past years produced six dead infants has a live healthy baby today because, while he was still a fetus, the project made it possible for him to have one of the latest of medical procedures, an intrauterine transfusion. Another mother, with a history of several miscarriages, today has a healthy infant because an obstetrician in the maternity clinic had the time, in a no longer overcrowded clinic, to notice that her cervix was beginning to open long before term and could arrange for corrective surgery. And a diabetic mother owes her possession of a healthy baby to the fact that tests, requiring the use of a laboratory 1,000 miles from the clinic, showed a dropped estriol content in her uterine, a sign of her need for an immediate Caesarean section.

The program's real meaning is perhaps best expressed by the patients themselves: in their behavior, as when all the patients of a maternity clinic showed up for their appointments during a blizzard so severe that it kept home all but three members of the staff; or by their verbal testimony, as that given by the West Virginia woman who, because of a project, had her ninth baby in a hospital—the first time she had ever been in one. Asked about the experience, she said:

"They kept a dim light on in my room all night, I got three hot meals a day, and the kindness of the doctors and nurses I will never forget."

[1] Lesser, Arthur J.: Accent on prevention through improved service. *Children*, January–February 1964.

*A hospital-based parent education project concentrates on . . .*

# IMPROVING PARENT CARE OF HANDICAPPED CHILDREN

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CONFRONTED frequently with major emotional disorders in the *families* of handicapped children, staff at the James Whitcomb Riley Hospital, Indianapolis, Ind., have been troubled by the thought that some secondary handicaps in these children, traceable to their families, might have been prevented. On the premise that such families constitute a population at special psychological risk, the authors of this article have been exploring a number of operational innovations at the hospital, designed to emphasize prevention as well as treatment in habilitation programs for handicapped children. Among these is a parent education program opened in 1961 and supported by a grant from the Junior League of Indianapolis.

The term "parent education" emphasizes two basic elements of the program: that it is *parent-* as well as child-oriented and that it involves *education* of the parents as part of the treatment of the child.

The design and objectives of this program have been based on the following observations:

1. ***The birth of a handicapped infant precipitates a family crisis.*** Whether the family arrives at a healthy or a maladaptive resolution of this crisis may be influenced, in some cases at least, by the intervention of physicians and other health workers.[1, 2] Parent-child and other family relations become organized, for better or for worse, in the early months, and are difficult to modify later. It is therefore important that the family be seen soon after birth and at frequent intervals thereafter. Many such families are not referred to appropriate centers until "there is something that could be done for the child"—surgery, physical therapy, or bracing.

2. ***Lack of communication is a striking deficit.*** While the lack of adequate discussion between professional disciplines and between parents and physicians is well known, the uncommunicativeness between many of the mothers and fathers is less appreciated. Often the father almost completely isolates himself from the care of the child, perhaps obtaining a job which keeps him away from home much of the time; less frequently, the mother withdraws from active care of the baby; in still other cases, both parents tend to deny responsibility for care of the baby.

3. ***The extent of parental misinformation is often great.*** Newspapers and magazines often compound the problem by giving information which emotionally involved parents cannot assimilate without individual help.

4. ***Parents of handicapped children often feel markedly inadequate.*** The statement, "I just don't know how to take care of a child with this handicap" is not a superficial parental remark. Otherwise resourceful parents seem surprisingly uncertain about growth and development steps and the day-to-day care of their handicapped child. They also seem fearful that they will do the wrong thing—and often do.

5. ***Understimulation is a frequent developmental threat.*** Such deprivation may occur in the child's



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home as well as in the institutional setting. Our experience indicates that the handicapped infant frequently has less contact with his mother than has the normal baby, and that he spends an inordinate amount of his day in a crib, a playpen, or a walker. This kind of experiential deficiency—one to which the handicapped child is especially vulnerable—occurs, in part, because the parents do not know what to do or what to expect. Said a mother of a blind baby, as if this were obvious: "He's blind. He doesn't do anything."

Since the effects of deficient environmental stimulation are more easily prevented than treated, parents of handicapped children need suggestions for providing age-adequate developmental and sensory experiences.

6. *The physician has his limitations.* The individual physician does not have at his immediate disposal all the services which these families need. The limitations—in part, those of interest, time, professional, and, in the case of teaching hospitals, the limited tenure of residents—are also very much the frequently unrecognized hesitancy of parents to trouble physicians with "trivial" questions, even when these represent truly major concerns. The auxiliary health worker is, in the mind of the parent, often more accessible than the physician.[3]

## *The Project*

The project has headquarters in the Parent Education Center which occupies two offices adjacent to the outpatient department of the James Whitcomb Riley Hospital. This is a 194-bed children's hospital located on the campus of the Indiana University Medical Center, Indianapolis. The director of education, an experienced pediatric nurse with additional training in maternal and child health, is a member of the department of pediatrics of the medical center and works closely with the director of the outpatient department.

Referrals to the Parent Education Center come chiefly from individual staff physicians, or as part of patient-management programs arrived at in the daily pediatric, diagnostic, teaching-disposition conferences or weekly habilitation review sessions. The director of parent education talks informally with the families of new patients after their arrival in the outpatient department, and is, therefore, able to contribute to the discussions in the diagnostic conference. Many parents also visit the Center spontaneously.

While the parent education project involves all handicapped patients to some extent, staff has become especially interested in blind infants, environmentally deprived children, neurologically impaired babies, and children with cystic fibrosis. An effort is being made to see the parents of such patients as soon after the child's birth as is practical, and at frequent intervals thereafter, especially during infancy and early childhood.

### *Interprofessional Communication*

One of the project's major contributions to the habilitation of children has been its success in reducing the interprofessional communication barrier among various types of hospital personnel, so that the skills of many persons can be brought to bear on the problems of the individual child. The program seeks to provide parents with practical suggestions for immediate, day-to-day problems of child care; suggestions for substitute modes of stimulation in the presence of sensory handicaps; methods of motivating mobility in the child with motor difficulties; and assistance in training for self-care. Such advice is given, as appropriate, by the nurse, the physical therapist, the occupational therapist, the social worker, the speech therapist, the psychologist, or the physician. As a result, these disciplines work closely together and so are giving greater help than previously to parents. Since both parents are encouraged to become intimately involved with the child's care, communication within the family is also enhanced.

While an attempt is made to integrate these multiple professional contributions, a certain amount of therapeutic pluralism seems to be important. For example, from the variety of professional contacts available, the parents may choose one person with whom to form a close and supportive relationship. In some cases, this is the physician; in others, the social worker, the parent educator, or the nurse. Therefore, for this program to be fully effective, all these professional workers must have a generic core of skills including a knowledge of child growth and development, especially in relation to the handicapped child, interviewing, and principles of parent-professional relationships. So far, inservice education of the staff in these areas has largely been accomplish in informal discussions, conferences, and suggestions for reading. Whether more structured training is needed requires further attention.

The integrated series of objective evaluations by the several professional persons available helps

parents toward a realistic appraisal of their child's handicap. The physician is also helped in his appraisal of parent-child interaction since the other professional persons who may talk with, and observe, the parents and child can give him their views. The structure of the program also makes it impossible for either the parents or the professional worker to evade important problems for very long.

Pamphlets, books, and other literature are available to parents of handicapped or nonhandicapped children without charge in the Parent Education Center. Fifty different publications are in stock. New publications are screened by the staff, and some of those which appear useful are obtained through the courtesy of the Indiana State Board of Health. Special materials are prepared by the hospital staff where adequate pamphlets are not available. A lending library is also being developed. An effort is made to use literature for parents selectively, at appropriate times, and not as a substitute for help from the physician or other professionals.

Although the project planners initially thought the library would be a major contribution to parent education, experience indicates that it is much less important than the other functions in the program. Noting that nurses and other allied health personnel who visit the Center are interested in these publications, we have come to believe that many of the pamphlets designed for parent education may be more properly employed as refresher texts for members of the staff, who can then communicate their content to parents—or be better prepared to answer their questions.

Movies on Mongolism, deafness, and normal growth and development are available for viewing by parents, individually or in groups. Since few commercially available educational films are appropriate for the purpose of the program, the Center plans to make special films and is at present preparing one which will demonstrate the longitudinal development of blind infants. Photograph albums are also available in the Center to help parents envision what the future holds. For example, an album which depicts the development of an infant with Mongolism in the process of bathing, self-feeding, playing, and being toilet trained has been very useful in this respect.

The Parent Education Center has also organized and directed a number of discussion groups of parents of infants with Mongolism, brain damage, cerebral palsy, and blindness. Some of these group activities have been directed by a social worker with group experience; others, moderated by the present director of parent education, are directed primarily toward educational, rather than psychotherapeutic, goals. The special advantages and disadvantages of parent groups have been discussed elsewhere.[4, 5]

An equipment loan pool was opened on June 1, 1964, as a section of the Parent Education Center. This facility is stocked with a great variety of equipment—strollers, rollator walkers, relaxation chairs, aspirators, infant seats, humidity tents, nebulizers—which parents may borrow for use in a home program under medical direction. Such equipment not only greatly facilitates the medical plan for the home care of the handicapped child but also serves as continuing and tangible evidence to parents of the support and interest of the habilitation team.

The parent educator also informally interviews parents in the outpatient department in order to gauge their understanding of their child's problems, the questions that need answering, and their ability to participate in the medical program. In doing this, she often gains information about important concerns that the parent will not bring up spontaneously with the physician. Also, parents stop into the Center to ask questions, and to express their puzzlement and frustration in relation to their child's progress. The parent educator, with the social worker, helps them to know what to expect from the physician and the hospital.

Parents often come back to the Center at times of crisis—the death of the child's father, injury of a father in an industrial accident, injury of a child by an automobile. Thus, the parent educator represents a person to whom the family feels close enough to turn to almost automatically at times of acute need. We believe that there is a correlation between such positive professional-parent relationships and the therapeutic alliance of the family with the hospital and physician.

### *Plans Ahead*

These parent education activities are soon to be extended to the community. Although local public health nurses are always contacted by the hospital for followup when the patient comes from distant parts of the State, communication with them is limited. With the addition of a "home-care" nurse in the hospital's outpatient department, as now planned, the extramural program will be strengthened in its efforts to insure that programs developed in the hospital are understood and implemented in the home. The nurse will spend much of her time in the field, to help in the home care of children with such prob-

lems as blindness, cystic fibrosis, meningomyelocele, and congenital heart disease. She will also conduct workshops for public health nurses and others in the community to broaden their roles in the home care of handicapped children.

Another plan is to establish an observation nursery school in the hospital. This facility for handicapped and environmentally deprived children, under the direction of an experienced nursery school teacher, will be helpful not only diagnostically, by assisting the staff to arrive at adequate understanding of a child's problems and capabilities, but also therapeutically, by providing the children with appropriate social group experiences. It will also have a parent education function, since the teacher will use her observations of the children to help their parents understand them.

The work of the Parent Education Center will also be greatly facilitated in the near future by the construction of a "parent-care" pavilion attached to the outpatient department. The patient will stay with one or both parents in this motel-like wing, with diagnostic and therapeutic procedures being conducted in the outpatient department.

The Parent Education Center represents an exploratory attempt to improve services to handicapped children. This developing program is based on the assumption that while the pediatrician has a broad responsibility in habilitation, the provision of truly comprehensive services requires him in many cases to share the treatment role with many other professional disciplines. The mobilization of these resources has been facilitated by the activities of the parent educator. Recognizing the parents to be the most important members of the treatment team, the total staff, working together, attempts to help them be comfortable in making adequate and effective contributions to their child's habilitation.

The program is not devised to substitute for the physician, nor to serve as a stop-gap measure to meet the shortage of physicians; rather, its goal is to enhance the physician's effectiveness by making the care of the handicapped more truly comprehensive.

Services to the handicapped child given in habilitation centers or outpatient departments cannot be fashioned exactly after the model of the private physician's office; their functions are not the same. As Stoeckle has reasoned: "While much of the planning and thinking about outpatient treatment is based on the idea of making it as good as, or like, a private doctor's office, there is a possible development in which the doctor-patient relationship may be less prominent. This is a program around the concept of therapeutic milieu. . . . This may eventually have repercussions on the one-to-one doctor-patient relationship as the major and preferred mode of therapy." [6]

The purpose of the Parent Education Center in the James Whitcomb Riley Hospital is to provide such a therapeutic milieu in an outpatient department as an extension of services provided by family and hospital physicians.

An important derivative effect of this project is that the pediatric house officer has accepted, at times with enthusiasm, a greater responsibility in habilitation than has been true in the past. Another is the demonstration of the opportunities all professional workers who come into contact with parents have to help parents toward positive rather than maladaptive solutions. Gradually, the various health workers have come to function largely as co-therapists in communication with each other, rather than as individual therapists working with the child in relative isolation.

This multidisciplinary approach was obviously not accomplished overnight or without frustrations. The introduction of a new professional role in the complex structure of a children's hospital naturally met with some resistance and many doubts. These difficulties, however, have been surmounted because the parent educator has been able to respect the role of other workers and has had no need to assume their therapeutic "prerogatives."

The parent education program thus seeks to provide family education and guidance for the individual handicapped child by a *family* of therapists. Because this project has had something to offer and because it has had strong medical support, it has gained impressive acceptance by both parents and professional staff and is now regarded as a permanent addition to the services of the hospital.

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*Styles of mother-child interactions reveal some clues to . . .*

# EARLY BLOCKS TO CHILDREN'S LEARNING

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IN THE CONTEXT of today's urgent need for preschool education, the central question is: Can we successfully intervene on a massive scale in the cycle of generation-to-generation transmission of poverty and semi-illiteracy? Any answer given at the present time would be based more on optimism than on experience and results. It would be naive, misleading, and irresponsible to make promises of easy success and instant results from large-scale programs intended to raise the educational level of children and families of low socioeconomic groups. There is some reason to be hopeful, but, at the present time, little basis for unrestrained enthusiasm.

Research now under way at the Urban Child Center of the University of Chicago is attempting to reach a greater understanding of two related questions: (1) When we strip away personal concern and sympathy for human tragedy, and after we discard the political slogans, what *is* cultural deprivation and how does it act to shape and depress the resources of the human mind? (2) How does cultural disadvantage affect the mind of the young child?

Our hypotheses are these: first, that the behavior which leads to social, educational, and economic poverty is socialized in early childhood, that is, it is learned; and, second, that the central factor involved in the effects of cultural deprivation is a lack of cognitive meaning in the mother-child communication system.

We proceed on the assumptions (1) that the structure of the social system and the structure of the family shape communication and language; and (2) that language shapes thought and cognitive styles of problem-solving. In the deprived-family context, this means that the nature of the control system which relates parent to child restricts the number and kind of alternatives for action and thought that are opened to the child. Such constriction precludes a tendency for the child to reflect, to consider and choose among alternatives for speech and action, and develops modes for dealing with stimuli and with problems which are impulsive rather than reflective, which deal with the immediate rather than the future, and which are disconnected rather than sequential.

This position draws from the work of Basil Bernstein of the University of London. In his view, language conditions what the child learns, and how he learns, thus setting limits to his future learning.[1] He identifies two forms of communication codes or styles of verbal behavior: *restricted* and *elaborate*.

Based on a paper presented at the National Conference on Day Care Services. The research described is supported by the Children's Bureau, the Ford Foundation, and the University of Chicago.

Restricted codes are stereotyped, limited, and condensed, lacking in specificity and in the exactness needed for precise conceptualization and differentiation. Sentences are short, simple, often unfinished; there is little use of subordinate clauses for elaborating the content of sentences: it is a language of implicit meaning, easily understood and commonly shared. It is the language often used in impersonal situations when the intent is to promote solidarity or reduce tension. Restricted codes are nonspecific clichés, statements, or observations about events, made in general terms that will be readily understood. By its nature, this mode limits the range and detail of concept and information involved.

Elaborate codes are those in which communication is individualized. The resultant message is specific to a particular situation, topic, and person: it is more particular, more differentiated, and more precise; and it permits expression of a wider and more complex range of thought, tending toward discrimination among cognitive and affective content.

Such early experiences affect not only the communication modes and cognitive structure; they also establish potential patterns of relationship with the external world. One of the dynamic features of Bernstein's work is his view of language as social behavior. As such, language is used by participants of a social network to elaborate and express interpersonal relationships and thus shape and determine these relationships. An understanding of the integral association between language and social structure is of critical importance for an understanding of the effects of poverty upon children. Within the individual family, this association emerges in terms of the principles which govern the decision-making activities, which, themselves, help regulate the nature and amount of social exchange.

### *Two Family Types*

The interlacing of social interaction and language is illustrated by the distinction Bernstein makes between two types of families—those oriented toward control by *status* appeal, or ascribed role norms, and those oriented toward *persons*.[2]

In status-oriented families, behavior tends to be regulated in terms of role expectations. There is little opportunity in these families for the unique characteristics of the child to influence the decision-making process or the interaction between parent and child, the internal or personal needs of the children not being influential as a basis for decision. Norms of behavior are stressed with such imperatives as "You must do this because I say so," "Girls don't act like that," or other statements which rely, for justification, on the status of the participants or a behavior norm.

In the person-oriented family, the unique characteristics of the child modify status demands and are taken into account in interaction. The decisions of this type of family are individualized and less frequently related to status or role ascriptions. Behavior is justified in terms of feelings, preference, personal and unique reactions, and subjective states. This philosophy not only permits, but demands, an elaborated linguistic code and a wide range of linquistic and behavior alternatives in interpersonal interaction. Status-oriented families may be regulated by less individuated commands, messages, and responses than person-oriented families. (Indeed, by its nature, the status-oriented family relies more heavily on a restricted code; the verbal exchange is inherent in the structure, regulates it and is regulated by it.)

These distinctions may be clarified by two examples of mother-child communication, using these two types of codes.

Assume that the emotional climate of two homes is approximately the same, the significant difference between them being in the style of communication employed. A child is playing noisily in the kitchen with an assortment of pots and pans when the telephone rings. In one home, the mother says, "Be quite," "Shut up," or gives some other short, peremptory command, and answers the phone while the child sits still on the floor. In the other home, the mother asks: "Would you keep quiet while I answer the phone?"

The questions our study poses are these: What inner response is elicited in the child in each of these two situations, and what is the effect upon his developing cognitive network of concepts and meaning?

In one instance, the child is asked for a simple mental response. He is asked to attend to an uncomplicated message and to make a conditioned response (to comply); he is not called upon to reflect or make mental discriminations. In the other example, the child is required to follow two or three ideas; he is asked to relate his behavior to a time dimension; he must think of this behavior in relation to its effect upon another person; he must perform a complicated task in following the communication of his mother, in that his relationship to her is mediated in part through concepts and shared ideas; and his mind is stimulated or exercised (in an elementary fashion) by

a more elaborate and complex verbal communication initiated by the mother.

As objects of these two divergent styles of communication, repeated in various ways, in similar situations and circumstances during the preschool years, these two imaginary children would be expected to develop significantly different verbal facility and cognitive equipment by the time they entered the public school system.

In our project, we view the child as an organism which receives a great deal of information of many kinds, much more than he can accommodate. What he responds to, how he interprets stimuli, and how he reacts to it, the child learns in interaction with the environment. In other words, he is taught what to attend to, how to interpret messages, and how to respond. These patterns of cognitive activity, socialized in early experience in the home, become the basis upon which the child's further cognitive development proceeds.

An analysis of language and social structure is necessarily concerned with the consequences of linguistic codes and their accompanying patterns of social interaction upon the developing cognitive faculties of the child. It is our argument that person-oriented families tend to justify behavior and emphasize its consequences; and that status-oriented families ask for rote learning and acceptance of the *status quo*—that is, they use a more rigid learning and teaching model, in which compliance, rather than rationale, is stressed.

### *The Project*

For our research, 160 Negro mothers and their 4-year-old children were selected from four different socioeconomic levels: Group A came from college-educated professional, executive, and managerial occupational levels; Group B from skilled blue-collar occupational levels, with not more than high school education; Group C from unskilled or semiskilled occupational levels, with predominantly elementary school education; and Group D from unskilled or semiskilled occupational levels, with fathers absent and family supported by public assistance.

These mothers were interviewed twice in their homes and brought to the university for testing in an interaction session between mother and child in which the mother was taught three simple tasks by the staff member, then asked to teach these tasks to the child.

One of these tasks was to sort or group a number of plastic toys by color and by function. The second was to sort eight blocks by two characteristics simultaneously. The third required mother and child to work together to copy five designs on a toy called "Etch-a-Sketch."

**As this mother helps her son with a test, they are observed by the investigators who are studying their interactions.**

The objective of the project is to relate the behavior and performance of individual mothers to the cognitive and scholastic behavior of their own children. We expect to follow the children of the study through the first 4 years of school, to obtain data on a more complete range of behavior. At our present, relatively early, stage of analysis, data are being examined in terms of social class differences among the four socioeconomic groups of the study—professional (middle), skilled workers (upper lower), unskilled (lower lower), and public assistance (AFDC). At this point in the project, our data about the cognitive behavior and language skills of the children are limited.

The wide range of individual differences in linguistic and interactional styles of these mothers may be illustrated by excerpts from recordings of one of the structured teaching situations, the task of the mothers being to teach the child how to group, or sort, a small number of toys.

The first mother outlines the task for the child, giving sufficient help and explanation to permit the child to proceed on his own. She says:

**"All right, this board is the place where we put the little toys. First of all, you're supposed to learn how to place them according to color. Can you do that? The things that are**

all the same color you put in one section; in the second section you put another group of colors and in the third section you put the last group of colors. Can you do that? Or would you like to see me do it first?"

*Child:* "I want to do it."

This mother has given explicit information about the task and what is expected of the child; she has offered support and help of various kinds; and she has made it clear that she impelled the child to perform.

The style of a second mother is not quite so easily grasped by the child. She says, in introducing the same task:

"Now I'll take them off the board; now you put them all back on the board. What are these?"

*Child:* "A truck."

"All right, just put them right here; put the other one right here; all right, put the other one there."

This mother relies more on physical signs and nonverbal communication in her commands; she does not define the task for the child; the child is not provided with ideas or information that he can grasp in attempting to solve the problem; neither is he told what to expect or, even in general terms, what the task is.

A third mother is even less explicit. She introduces the task as follows:

"I've got some chairs and cars. Do you want to play the game?"

The child does not respond.

Stimulating a child's curiosity about books is one goal of this preschool center. Such programs, research suggests, must also show children how ideas and events are related.

The mother continues: "O.K. What's this?"

*Child:* "A wagon?"

*Mother:* "This is not a wagon. What's this?"

The conversation continues with this sort of exchange. Here again, the child is not provided with the essential information he needs to solve or to understand the problem. There is clearly some coercion, on the part of the mother, for the child to perform; but the child has not been told what he is to do.

Each teaching session was concluded with an assessment by a staff member of the extent to which the child had learned the concepts taught by the mother. His achievement was scored in two ways: first, the ability to place or sort the objects correctly; and second, the ability to verbalize the principle on which the sorting or grouping was made.

### *Social Class Differences*

There were marked social class differences in the ability of the children to learn from their mothers in the teaching sessions. Children from middle-class homes ranked above children from the lower socioeconomic levels in performance on these sorting tasks, particularly in offering verbal explanations as to the basis for sorting. Over 60 percent of middle-class children placed the objects correctly on all tasks. The performance of children from the other groups ranged as low as 33 percent correct. Approximately 40 percent of the middle-class children who were successful were able to verbalize the sorting principle. Children from the lower socioeconomic groups were, on the whole, less able to explain the sorting principle. These differences clearly paralleled the relative abilities and teaching skills of the mothers from the different groups.

The differences among the four socioeconomic levels were apparent not only in sorting and verbal skills, but also in the mother's ability to regulate her own behavior and her child's in performing tasks which require planning or care rather than verbal or conceptual skill.

These differences were revealed by the mother-child performance on the "Etch-a-Sketch" task.

An "Etch-a-Sketch" toy is a small, flat box with a screen on which lines can be drawn by a device within the box. The marker is controlled by two knobs: one for horizontal movement, the other for vertical. The mother is assigned one knob, the child the other. The mother is then shown several designs which are to be reproduced. Together, they attempt to copy the

models. The products are scored by measuring deviations from the original designs. The mother decides when their product is a satisfactory copy of the original designs.

These sessions were recorded, and the nonverbal interaction was described by an observer. Some of the most relevant results were these: middle-class mothers and children performed better on the task (14.6 points) than mothers and children from the other groups (9.2; 8.3; 9.5). Mothers of the three lower socioeconomic groups were relatively persistent, rejecting more complete figures than the middle-class mothers; mothers from the middle class praised the child's efforts more than other mothers did, but gave just as much criticism; the child's cooperation, as rated by the observer, was as good or better in low socioeconomic groups as in middle-class pairs; and there was little difference between the groups in affect expressed to the child by the mother.

In these data, as in others, the mothers differed relatively little in the affective elements of their interaction with their children. The gross differences appeared in the verbal and cognitive environments which they presented. The significance of the maternal environment lies not only in the lack of verbal exchange but also in the kind of interaction that develops between learner and teacher. Mothers of blue-collar classes appear to be socializing passive learning styles on the part of the child, teaching him to be docile in such learning situations—in contrast to the more active, initiatory behavior of the child from a middle-class home.

### *One Question, Several Responses*

The women in the study also varied in their perception of school. Applying Bernstein's concept of status-oriented and person-oriented families to our data, we analyzed maternal responses to the question: "Imagine your child is old enough to go to public school for the first time. How would you prepare him? What would you tell him?"

One mother, who was person-oriented and used elaborated verbal codes, replied as follows:

**"First of all, I would remind her that she was going to school to learn, that her teacher would take my place, and that she would be expected to follow instructions. Also that her time was to be spent mostly in the classroom with other children, and that she could consult with her teacher for assistance on any questions or problems that she might have."**

**"Anything else?"**

**"No. Anything else would probably be confusing for her at her age."**

In terms of promoting educability, what did this mother do in her response? First, she was informative, presenting the school situation as comparable to one already familiar to the child; second, she offered reassurance and support to help the child deal with anxiety; third, she described the school situation as one which involves a personal relationship between the child and the teacher; and fourth, she presented the classroom situation as one in which the child was to learn.

A second mother responded as follows to the same question:

**"Well, John, it's time to go to school now. You must know how to behave. The first day at school you should be a good boy and should do just what the teacher tells you to do."**

In contrast to the first mother, what did this mother do? First, she defined the role of the child as passive and compliant; second, the central issues she presented were those dealing with authority and the institution, rather than with learning; third, the relationship and roles she portrayed were sketched in terms of status and role expectations, rather than in personal terms; and fourth, her message was general, restricted, and vague, lacking information about how to deal with the problems of school, except by passive compliance.

These responses illustrated the tendency for status-oriented families and relationships to restrict the linguistic codes used in communication. The child who comes to school with a status orientation is prepared to engage in rote learning with passive acceptance of school authority in the learning situation. His initiative and participation in the learning possibilities of the school are meager. Not all such children accept the authority of the school in this unquestioning fashion, but they have few alternatives except to resist and rebel. The range of choice open to them is limited by the nature of the cognitive and interactional environment in which they have had experience.

A more detailed analysis of the mothers' responses to this question grouped their statements as *imperative* or *instructive*. An imperative statement was defined as an unqualified injunction or command, such as: "Mind the teacher and do what she tells you to do," or "The first thing you have to do is be on time," or "Be nice and do not fight." An instructive statement offers information or commands which carry a rationale or justification for the rule to be observed. Examples: "If you are tardy, or if you stay away from school, your marks will go down," or "I would

tell him about the importance of minding the teacher. The teacher needs his full cooperation. She will have so many children that she won't be able to pamper any youngster."

### *Cultural Deprivation*

Against this background let us return to the problem of the meaning, or perhaps more correctly, the lack of meaning in cultural deprivation. One of the features of the behavior of mothers and children of lower socioeconomic class is a tendency to act without taking sufficient time for reflection and planning. In a sense, one might call this impulsive behavior, not the acting out of unconscious or forbidden impulses, but a type of activity in which a particular act seems to be unrelated to the act that preceded it, or to its consequences. In this sense, it lacks meaning; it is not sufficiently related to the context in which it occurs, to the motivations of the participants, or to the goals of the task.

This behavior may be verbal or motor and it shows itself in several ways. On the "Etch-a-Sketch" task, for example, the mother may silently watch a child make an error, and then punish him. Another mother will anticipate the error and warn the child that he is about to reach a decision point; she will prepare him by verbal and nonverbal cues to be careful, to look ahead, and avoid the mistake. He is encouraged to reflect, to anticipate the consequences of his action and in this way avoid error.

Recall the example of the mothers and the telephone calls: one child was prompted to relate his actions to those of another person and to a time dimension, to delay, to observe, and to consider the consequences; the other was given a command that called for no reflection and did not require him to relate his behavior to the context in which it occurred. This is a model of a conditioned response, rather than a problem-solving strategy. A problem-solving approach requires reflection and the ability to weigh decisions, to choose among alternatives. The effect of restricted speech and of status orientation is to foreclose the need for reflective weighing of alternatives and consequences. The use of an elaborated code, with its orientation to persons and to consequences (including future), tends to produce cognitive styles more easily adapted to problem-solving and reflection.

The objective of our study is to discover how teaching styles of the mothers induce and shape learning styles and information-processing strategies in the children. The picture that is beginning to emerge is that the meaning of deprivation is a deprivation of meaning—a cognitive environment in which behavior is controlled by status rules, rather than by attention to the individual characteristics of a specific situation, and one in which behavior is not mediated by verbal cues or by teaching which relates events to one another and the present to the future. This environment produces a child who relates to authority rather than to rationale; who, although often compliant, is not reflective in his behavior; and for whom the consequences of an act are largely considered in terms of immediate punishment or reward, rather than future effects and long-range goals.

### *Program Implications*

If this picture is substantially correct, there are several implications for preschool programs.

For example, it would argue that enrichment for the sake of enrichment may miss the point—that it is not additional, or even more varied, stimulation that is needed, but experiences which give stimuli a pattern of sequential meaning. It argues that such programs must not merely teach the child new words, but must show the child how ideas and events are related to one another. And it argues that the transition that a child must make from a cognitive style of immediate reactivity to one of problem-solving must be made by experiences with authority, not with machines.

When the data are more complete, a more detailed analysis of the findings will enable us to examine the effect of maternal cognitive environments in terms of individual mother-child transactions, rather than in the gross categories of social class. This analysis will not only help us to understand how social class environment is mediated through the interaction between mother and child, but will also give more precise information about the effects of individual maternal environments on the cognitive growth of the young child.

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*An experiment to keep dependency from nurturing dependency through . . .*

# RAISING THE LEVEL OF CHILDREN'S ASPIRATIONS

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ONE DAY in the winter of 1962, a shabbily dressed, bright-eyed youth said to me with a broad smile: "When I grow up, I'm going to be a doctor."

For an instant, I was not sure what my response to him should be. There seemed to be too many obstacles for him to overcome. First, his family—including 7 brothers and sisters—had been recipients of public assistance for the past 10 years. Secondly, he was a Negro. Either one of these facts, considered by itself, tended to lead to a negative prognosis. I carefully considered them before answering:

"When you grow up, you can be a doctor . . . ."

I was not trying to be "nice" or to "spare his feelings." On the contrary, I sincerely believed that the boy could become a doctor. And, more important, I was willing to assist in making that dream come true. Thus began the Detroit Urban League's 1962 Family Life Pilot Project.

Others had designed and executed projects aimed at motivating and helping adults to get off public subsidy rolls. Usually, these had a short-range goal—to produce financially independent families within a short period of time. For the lack of better terminology, such activities have been referred to as "strengthening family life" projects. Among them was a 1960 project of the Detroit Urban League aimed at helping a small group of mothers who were recipients of aid to families with dependent children to become self-supporting.

At the completion of this 1960 project, the staff noted many facts, the foremost being: That it was *too late* to prevent public subsidy from being a way of life for many of the adults. For one reason or another—functional illiteracy, poor health, or other intrapersonal problems—they had become chronic public assistance cases. Thus, it appeared that short-range projects alone could not significantly curtail the public subsidy caseloads. At best, such projects are more corrective than preventive. Perhaps the more fruitful and long-range approach, the staff surmised, should center on children. For while it may have been too late to change the lives of those adults regarded as "chronic cases," we felt that we still had time to prevent public subsidy from becoming an acceptable or inevitable pattern for their children.

### *Designing the Project*

Our preliminary work on the 1962 project began in September of 1961 when we consulted several sources for guidance—university professors, social workers, books, and journals. It quickly became evident that no one had undertaken such a project. The majority of efforts to raise the sights of children had been designed either for the exceptionally "bright" or for the exceptionally "dull" students in nonwelfare homes. None specifically considered the barriers to children's aspirations created by public subsidy. We were told by a number of persons that our proposed project was not feasible. Although we did not find a program guide, we were determined to proceed.

The journals were important, however, in focusing our attention upon levels of aspiration. We came to realize that although chronic public assistance cases may be directly related to easily discernible factors, such as economic and social conditions, they may also be related to the less discernible factor of the individual's *level of aspiration*, the degree of his *ambi-*

*tion in a dynamic social situation.* Because aspirations refer to the future, we immediately became aware of the fact that the reliability of any aspiration project not connected with a longitudinal study must be limited. Yet, we felt that this was a valid approach to curbing public subsidy cases.

The project we devised centered on raising children's levels of aspiration, specifically in relation to their future vocations. Our initial question was: "How can children predict success or degrees of achievement in tasks in which they have no experience?" The answer to this, the literature revealed, is that the expressed goals (or aspiration levels) of children tend to reflect the mean of performance of the group with which they identify. Or, to be more specific, a child is believed to evaluate his "life chances" in references to those with whom he identifies. Differences in aspiration levels among different groups of children, we concluded, are not so much a function of the children's ages as a function of social and economic strata identification.

Those who warned us against the project used the identification factor as their major argument. Since "welfare children" identify with "welfare parents," they said, such children do not share in the American tradition of wanting to get ahead. In fact, our antagonists maintained that this was generally true of children in the lower socioeconomic classes.

We believed, however, that in spite of social and economic deprivation, children in lower socioeconomic classes often aspire to significantly higher occupational statuses than their parents, and that these upward shifts usually approximate the next higher class—the middle class. We proceeded on the theory that *the difference between middle and lower class children may not be the achievement motive but their structural opportunities.*

At this point, we realized that our role would have to be similar to the role of middle-class mothers who, according to many social scientists: (1) make more demands on their children, especially for evidence of maturity, independence, and achievement; and (2) give more intense and frequent rewards for fulfilled demands. The key to success, we ventured, is that children of low socioeconomic backgrounds must not only be taught to believe in success, but be willing to take steps making achievement possible.

Our interest in level of aspiration was an interest in *reversing* the operation of three well-known principles of motivational psychology: (1) After success, an individual usually will set a higher goal; (2) after failure, his level of aspiration usually will go down; or (3) after failure, a person may cease having any aspirations at all.

Students of low socioeconomic backgrounds, we reasoned, should be advised that they need not set their sights low or raise them only after achieving success. On the contrary, they should be advised that, *within their mental and physical capacities*, they should pursue the highest levels of their interests at the initial planning stage. Such pursuit, however, must be based in reality; students must realistically expect to fail not once but many times. In essence, our rationale embodied the belief that children of low socioeconomic status should not be channeled into the so-called "lower class jobs." To do so would be to create and bring about a self-fulfilling prophecy that such children are doomed to lower class status. Unfortunately, too many children of low socioeconomic backgrounds are denied the votes of confidence and opportunities of experience that are necessary for success. Parents, teachers, social workers, employers, and even the children themselves are guilty of such denial.

Our rebuttal to arguments against the project was: "If adults of low socioeconomic background must compete in a basically middle-class oriented society—and they do—then, as children, they must be prepared for such competition. Therefore, because of their relative deprivation, children of low socioeconomic status need not less education, but more; not less motivation, but more."

### *Arrangements*

We decided to secure a sample of 50 students from the Detroit Department of Public Welfare, Bureau of Social Services, the professional casework division of the department. Because of the small size of their caseloads and their intensive casework treatment with assigned families, the caseworkers in this bureau were relied on to select young participants who might benefit from such a program but who, if not stimulated to greater motivation, would probably become welfare clients themselves.

Following a series of meetings with the welfare department officials, we received a letter from the director of caseworkers outlining the following selection procedures:

> **Our welfare referrals will be children born between March 1, 1946, and September 1, 1948, i.e., some may become 16 before the project is concluded, and some may have just had their 13th birthdays before the project begins.**
>
> **We appreciated your recognition of our feeling that these children should be helped to seek a "higher level of economic and social achievement rather than 'the highest' and that these**

goals should be 'consistent with their fullest potential'. . . ."

We will initiate the referral process by a home call and a letter in as many cases as possible and solely by letter in others, if necessary. After this step has been taken, we will send you a separate letter for each case, containing (pertinent) social information. . . .

This will be provided with the understanding that it is for your professional consideration, and will not be shared in toto with members of your advisory committee or other lay persons.

We further understand that you will call on the children selected to appraise them and their parents of the nature and hours of the sessions and of their progress. . . .

The department will furnish bus tickets for the children to attend the sessions.

We shall plan to refer one child from each of 50 homes, if possible, but . . . this may not be possible because our present caseload in the two units of the Bureau of Social Services is less than 300 in all, and you have agreed to accept referral of more than one child in a family in order to have at least 50 in the beginning group. . . .

It was agreed at a subsequent meeting that referrals would consist of children (1) from families which had been public assistance recipients for 5 or more years, (2) with no case histories of severe mental disorders, (3) who "appeared" to have the manifest or latent ability to succeed in school.

We discussed the relative advantages and disadvantages of having only children from the public assistance rolls attend the workshop and considered the possibility of arousing guilt, shame, or persecution complexes. We concluded, however, that, as a rule, such children are known by their peers to be recipients of public assistance, that most such children adjust to these conditions, and—as was borne out later—they would enjoy having a workshop especially for themselves. The fact that community leaders thought enough of their potential to arrange such a workshop, it was believed, would override any stigma attached to a welfare-segregated session.

### *The Children*

The initial sample consisted of 56 Negro students, boys and girls, between the ages of 13 and 16. Later, we added 17 white students in order to dispel implications that the "welfare problem" is a "Negro problem." By having a racially mixed sample, we focused upon the problems of "welfare children" and not "welfare Negroes." Sixty-three of the students (46 Negroes and 17 whites) agreed to participate.

The school counselors and principals, using a form that we designed, rated the students' chances, with and without a change in motivation, of finishing high school and, perhaps, going to college. The form also included estimates of the students' future grades, with and without a change in motivation.

The school personnel predicted that *without* a change in motivation, 26 of the students selected for the workshop would *not* finish high school. They also predicted that even with a change in motivation, *none* of the participants would go to college. In terms of grades, the school personnel predicted that even with a change in motivation less than 10 percent of the students would perform above "C" level.

After securing the sample, we obtained commitments from 27 community leaders, representing a variety of professions and occupations, to *talk with* the students about success and failure.

The speakers were told that they would have the task of letting the students know three things:

1. That we (the Detroit Urban League and many Detroit officials) are *sincerely interested* in them;

2. That we *sincerely believe* that it is possible for them to succeed;

3. That for those who show that they want to succeed, we will offer valuable *community assistance*—scholarships, employment references, remedial school assistance. Local universities, business schools, and the Detroit Urban League were among the organizations which offered such assistance. (As it turned out, one student received a high school scholastic scholarship, two received tuition grants from Wayne State University, and the Detroit Urban League gave one student a college tuition grant.)

The 2-hour workshop sessions were set up for 16 Fridays between February 2, 1962, and June 1, 1962, from 4 to 6 p.m. Food was served before the formal sessions began. Each session was divided into two parts: (1) a general assembly for community resource speakers to talk with the students and (2) four small discussion groups, each having an Urban League staff member as a discussion leader. For control, each child was assigned to a permanent discussion group. And for the sake of experiment, we divided the discussion groups into four categories:

1. Twelve students in grades 9 through 12 (6 boys and 6 girls).
2. Twelve boys in grades 7 and 8.
3. Twelve girls in grades 7 and 8.
4. Twenty-seven students in grades 6 through 8. This group contained 18 boys and 9 girls.

Our major techniques were:

1. ***Repetition.*** The students were told over and over again that it was possible for them to su ed.

This theme was stated directly and indirectly. Vivid examples of known ex-welfare persons (often the speakers) who had succeeded were presented to spark rays of hope in the youths.

2. ***Truthfulness.*** In citing examples of success, the speakers did not overlook the possibility of failure. Thus, the students were told that every successful person has failed in some endeavor, but they did not give up; that often, in order to succeed, many sacrifices would have to be made—studying longer hours, going without proper diets, and foregoing luxuries.

The youth workshop was organized and carried out under the same conditions as an adult workshop: (1) a preregistration period was held to give the students an opportunity to notify us in advance of their intention to participate; (2) registration lists were maintained outside the door of the meeting room, and students were required to check in at the registration desk; and (3) name tags were given to participants.

Among the 27 resource speakers (two per meeting) were: a physician, who discussed "Anatomy of a Student: Physical and Psychological"; a dean from Wayne State University, who discussed "You and Your Family: Likenesses and Differences"; a representative of the Detroit Police Youth Bureau, who discussed "You and Your Friends: Likenesses and Differences"; the chairman of the University of Detroit's sociology department, who discussed "What Is Failure?"; a judge of the U.S. Circuit Court, who discussed "What Is Success?"; a city councilman, who discussed "Failure and Success: True Life Stories"; the superintendent of the Detroit Public Schools, who discussed "An Educator's Point of View"; the personnel director of General Motors, who discussed "An Employer's Point of View"; and the president of the Wayne County AFL–CIO, who discussed "A Worker's Point of View."

The initial reaction of the students was *status* shock. Most students could not believe that such highly "successful" people were really interested in them. It took one whole session before the students would ask the speakers questions, either during the question period after their presentations or during the small group discussion sessions during which the speakers circulated between the groups.

Fortunately, the status shock wore off quickly and subsequent sessions were characterized by lively questions and answers. The students' questions ranged from "Why don't the teachers like us?" to "Are good grades the only thing that employers look for when they hire people?" or "Will my home address influence my getting a job?" Although most speakers alerted us before the sessions that they would have to leave shortly after their presentations, few actually left before the sessions ended. They could not, as one speaker stated, "tear away from the kids."

### *The Discussions*

During the discussion groups, the students opened up and "got things off their chests." The adult discussion leaders noted that most of the students wanted to talk about "things"—ranging from themselves to the American society in general. As they talked, they almost immediately revealed that, for the most part, they had very low appraisals of their "life chances" to succeed.

Typical responses to the question of why they felt they would not succeed in life were: "Because I've never had anything." Their pessimism was compounded by such normal teenage complaints as: "My parents are old-fashioned and don't understand me;" I can't stay out late enough;" "There's nothing for kids to do."

A dangerous thread ran through most of the discussions: "Because we are poor, nobody cares about us—the teachers don't care, the police don't care, my friends don't care, and I don't care." Even those few students who felt they had "someone who cared" seemed to see the world around them as denying their chances of becoming socially acceptable successes. They said they saw in their immediate environments many idle, unemployed youths who had graduated from high school. What, then, could a high school diploma do for them? They also told about others who had not graduated from high school but who were earning "fabulous" sums of money in illegal ways.

After one of the speakers, a Federal judge, suggested that many of the people having illegal occupations, expensive clothes, big automobiles, and well-decorated houses could not enjoy these items because of running the risk of being caught by the police, some students commented that they would rather be "poor and honest than rich and dishonest."

Although most students expressed desires to become socially acceptable successes, few seemed to have any idea what they would have to do in order to achieve such success. One girl, for example, was overjoyed to learn the steps that she would have to take in order to become a social worker. In their discussions, the students revealed a shocking ignorance of the broad range of middle-class occupations

in our society. The sessions prompted many students to seek out relevant information from school counselors, libraries, and other sources.

The students were praised for whatever progress they showed in the workshop and in school. We seized every opportunity to show them that "somebody *does* care."

At the awards session on June 1, 1962, all of the students received certificates of completion. Ten students also received gift certificates for outstanding workshop participation and scholastic achievement (B+ averages in school). About 150 people—including 60 of the original students—attended the final awards session.

### *Some Impressions*

I would like to be able to say that the project was a complete success. However, in only 16 workshop sessions, we could only begin a much needed task of raising economic levels of aspiration. And, because aspirations refer to future time periods, our appraisal of the workshop to date can consist only of incomplete impressions. The following are some of my immediate impressions of the first workshop.

We know we made some mistakes in designing and running the project—insufficiently broad participation in planning, a lack of alternative schedule for times when scheduled speakers failed to arrive on time, a failure to consider ethnic and religious characteristics in planning the food for the initial sessions, insufficient plans for parent participation, insufficient work with school counselors and with teachers, inadequate time at each meeting for the student discussions, insufficient staff and budget, and in one instance an inadequate discussion leader. We also had difficulties because of the wide radius from which the students came—from 39 schools within a 4-mile radius of the Urban League's office, resulting in many late arrivals from the more distant schools.

Nevertheless, we believe we can identify a number of positives directly associated with, if not resulting from, the project:

1. The racially integrated nature of the project made clear to all who participated in its planning and operation that the public subsidy problem is a *community* problem—not a Negro problem.

2. Our drawing in 120 influential people as speakers and resource persons working directly in the project spread an awareness and concern for the young people in public welfare programs in places where it counts.

3. Many of the students realized for the first time that someone cares what happens to them.

4. On an average, the academic achievement grades of the students were raised slightly—for example, from C to C+ or B to B+.

5. On an average, the citizenship grades of the students were raised considerably, from C to B, from B to A.

6. On an average, the students missed fewer school days during the semesters of the workshop.

7. All of the students wanted to continue meeting in the fall. In fact, they asked to continue throughout the summer. While our program commitments would not allow for a summer workshop, we did conduct a followup workshop in September 1962.

### *Followup*

The students who attended the second workshop were 30 members of the original workshop group who had volunteered for additional sessions. The sessions, less structured than those of the first workshop, continued until June 1963. During the second workshop, we employed both field trips and community speakers. It gradually evolved into a tutoring project which combined the techniques utilized in the pilot aspiration programs as well as direct skill improvement services. Similar tutoring projects for low achieving students were carried on by the Urban League in cooperation with the Detroit Public Schools and Mercy College in 1964 and 1965.

Followup school and home visits were made in December 1964 in regard to the 63 students who participated in the 1962 pilot project raising aspiration levels. We found that:

1. Of the 10 students who had graduated from high school, 2 were in college.

2. While four of the students had dropped out of school, the others, excluding the graduates, were still in school.

3. Of the 49 students still attending school, 11 were receiving above-average grades; 25, average grades; and 13, below-average grades.

The final evaluation will come after the students succeed or fail in their scholastic and occupational endeavors. Hopefully, the project was the beginning for doctors, lawyers, electricians, nurses, and other workers to emerge from public assistance backgrounds. Only time can tell.

# BOOK NOTES

THE CHILD. William Kessen. John Wiley & Sons, New York. 1965. 301 pp. $4.95, clothbound; $2.95, paperback.

This book is the fourth in the "Perspectives in Psychology" series edited by Mr. Kessen and George Mandler.

Mr. Kessen, a member of the department of psychology, Yale University, describes his volume as "a book of readings in the history and prehistory of child psychology" which are "largely theoretical" but with an "abiding link with practical action." They were all chosen from Western sources, the earliest (John Locke's "Rewards, Reputation, and Curiosity") having been written in 1693 and the latest (Jean Piaget's "The Growth of Thought") in 1942.

The 16 articles are divided under 5 headings: "Precursors: Physicians and Reformers." "Precursors: Philosophy and Teachers," "Darwin and the Beginnings of Child Psychology," "Development and Diversity: 1900–1930," and "Workers of a Grand Design: Freud and Piaget."

The editor provides extensive commentary on both the topic areas of the main headings and the individual articles.

THE NEXT GENERATION: the prospects ahead for the youth of today and tomorrow. Donald N. Michael. Random House, New York. 1965. 218 pp. $4.95, clothbound; $1.65, paperback.

A look at what society will be like 20 years from now is provided in this book, which is based on a report prepared in 1963 for the Office of Juvenile Delinquency and Youth Crime, U.S. Department of Health, Education, and Welfare.

The author, a social psychologist, who is a resident fellow of the Institute for Policy Studies in Washington, D.C., predicts that the increased complexity of society will result in more intense conflicts between community interests and between personal and social values. He also foresees radical alterations in community and family life resulting from new technologies—in cybernetics, communications, biology, and industry.

The first section of the book explores coming developments in the national economy, technology, and the evolution of urban communities; and speculates on what may happen in the developed and underdeveloped parts of the world, as these relate to the possibilities for peace and war. The second section studies trends and circumstances more within the control of the planners of youth development programs—and the related topics of sex, marriage, and education. The third examines prospects in the areas of work, leisure, values, and viewpoints, as they may be influenced by conditions speculated upon in the first two sections.

The book concludes with a summary of what the next 20 years may hold—a picture of an unwieldy society with "overtones of Huxley and Orwell," though "too full of contrary trends and unanticipated consequences for anything so monolithic" as these authors have imagined. Among the prospects: increased welfare problems growing out of the sheer size and complexity of society; and increased differences between the "haves" and the "have-nots," between the educated "elite" and the educationally underprivileged or mentally underendowed; and between the socially concerned and the indifferent.

The author concludes:

". . . we must explore, more honestly and intensively than most of us ever do, which of the values and goals that we hold dear are appropriate to inculcate in youth for living in tomorrow's world—or for ourselves to live by in planning for and guiding [youth]. . . ."

ATTITUDE CHANGE AND SOCIAL INFLUENCE. Arthur R. Cohen. Basic Books, New York. 1964. 156 pp. $2.95.

This volume, a posthumous publication of a late associate professor of psychology at New York University, summarizes much of the evidence that research has adduced on the topics of attitude change and social influence. Concerned largely with the results of controlled laboratory experimentation, rather than with surveys, the author discussed the results of studies analyzing—in terms of learning, perception, motivation, and cognition—the effectiveness of arguments and appeals, the personality factors underlying the acceptance of influence, the effects of social roles and interactions.

In his conclusion, Professor Cohen noted that the degree to which outer conformity to persuasive appeals is transformed into inner change "is still little understood," but added that "there are hints toward understanding the conditions under which internalization occurs." Further pointing out that little research has been done to examine "the behavior that may follow a change in attitude," he suggested: "Until experimental research demonstrates that attitude change has consequences for subsequent behavior, we cannot be certain that our procedures for inducing change do anything more than cause cognitive realignments."

DELINQUENCY AND CHILD GUIDANCE: selected papers. August Aichhorn. Edited by Otto Fleischmann, Paul Kramer, and Helen Ross. International Universities Press, New York. 1964. 244 pp. $5.

Paul Kramer, one of the editors of this selection of papers by the Viennese psychoanalyst, who died in 1951, explains in the introduction that these essays continue and extend the ideas presented in Aichhorn's best known work "Wayward Youth" (a translation, published in 1925, of his *Verwahrloste Jugend*). Kramer emphasizes Aichhorn's "fundamental view" that delinquency is "a condition the beginnings of which reach into the past long before the appearance of actual symptoms."

The book's seven chapters consist of essays on the application of psychoanalytic understanding in dealing with juvenile delinquents, under the headings: "On Education in Training School," "On the Problem of Wayward Youth," "The Juvenile Court: Is it a Solution?" "Reward or Punishment as a Means of Education?" "On the Technique of Child Guidance: the Process of Transference," "The Education of the

Unsocial," and "Delinquency in a New Light."

STABILITY AND CHANGE IN HUMAN CHARACTERISTICS. Benjamin S. Bloom. John Wiley & Sons, New York. 1964. 237 pp. $7.

The author, a professor of education at the University of Chicago, after examining a large mass of data from hundreds of longitudinal studies of the "shaping" of human beings from infancy to adulthood, concludes, among other findings, that change measurements are highly related to the environmental conditions in which individuals have lived during the change period; and that environmental variations have the greatest quantitative effect on a characteristic during that characteristic's most rapid change period, and the least effect during its least rapid change period.

In general, Professor Bloom's findings reveal the great importance of the first years of life for all the years that follow. "A central thesis of this work," he writes, "is that change in many human characteristics becomes more and more difficult as the characteristics become more fully developed. Although there may be some change in a particular characteristic at almost any point in the individual's history, the amount of change possible is a declining function as the characteristic becomes increasingly stabilized."

The purpose of the book, the author states, is to identify "stable characteristics," and to determine the conditions under which their stability may be modified.

SOCIAL WORK AND SOCIAL PROBLEMS. Edited by Nathan E. Cohen. National Association of Social Workers, 2 Park Avenue, New York, 10016. 1964. 391 pp. $3.50.

The seven essays in this volume are the first fruits of a project of the National Association of Social Workers to define more clearly the contribution of social work to the solution of social problems. Developed on the basis of a value-oriented model for analysis intended to emphasize the gaps between ideal objectives and actual operations, they focus on the following problems: poverty (by Norman Lourie); marital incompatibility (by Werner A. Lutz); child neglect (by Elizabeth G. Meier); deterioration of the inner city (by Lawrence K. Northwood); unmarried mothers (by Helen Harris Perlman); the broken family (by Otto Pollak); and racial discrimination (by Whitney M. Young, Jr.).

Each paper examines the values within the community as well as within the social work profession which tend to deflect or fragment the profession's efforts to attack the problem under scrutiny. In the final chapter, the editor, in examining the usefulness of the model for analyzing social problems, points to the need for "new alignments" if the profession of social work is to raise its sights from its traditional clinical orientation to a concern for the "primary prevention" of social problems.

# Guides and Reports

GUIDE FOR REFERRAL OF FAMILIES TO COMMUNITY HEALTH AND SOCIAL SERVICES. Department of Maternal and Child Health, Harvard School of Public Health, 55 Shattuck Street, Boston, Mass., 02115. 1965. 164 pp. $3.15.

This guide, prepared primarily for use by a child health clinic staff in one city, identifies the interrelated health and social problems affecting the well-being of children and their parents, and outlines procedures for obtaining supplementary agency services needed by families with special problems.

WORLD OF PROMISE: A GUIDE TO THE UNITED NATIONS DECADE OF DEVELOPMENT. James Avery Joyce. Oceana Publications, Inc., Dobbs Ferry, N.Y.; and UNESCO Publications Center, 317 34th Street, New York, 10016. 1965. 166 pp. Paperback, $1.75 (UNESCO Publications Center); clothbound, $3.50 (UNESCO or Oceana).

This illustrated guide describes the efforts of the United Nations and its affiliated agencies to mobilize both human and natural resources in underdeveloped countries, to develop skills to improve living conditions and realize national goals.

COMPENSATORY EDUCATION FOR CULTURAL DEPRIVATION. Benjamin S. Bloom, Allison Davis, and Robert Hess. Holt, Rinehart and Winston, Inc., New York. 1965. 179 pp. $1.75.

A summary of the findings of the working papers contributed by participants in the Research Conference on Education and Cultural Deprivation, held at the University of Chicago, June 8–12, 1964, with recommendations under three broad headings: national responsibilities, school-community responsibilities, and school responsibilities. Also included is an annotated bibliography on education and cultural deprivation, prepared by Susan B. Silverman.

DEVELOPMENT OF SELF-REPORT INSTRUMENTS IN DELINQUENCY RESEARCH: a conference report. Robert H. Hardt and George E. Bodine. Syracuse University Youth Development Center, 926 South Crouse Avenue, Syracuse, N.Y., 13210. 1965. 33 pp. $1.

Summarizes the presentations and discussions of nine investigators' techniques for securing data on past delinquency-type behavior and activities from the persons involved, for analysis in determining the extent of such behavior and factors pertinent to prevention. An appendix includes samples of self-report questionnaires and interviews.

# HERE AND THERE

## *Federal Legislation*

New programs to improve the health of children and expansion of existing provisions for children are authorized under the 1965 amendments to the Social Security Act (Public Law 89-97), signed by the President on July 30. In addition to the widely publicized provisions for medical care for the aged and liberalized old age and survivors insurance benefits, the amendments authorize:

• A new 5-year program of special projects grants to State or local health agencies or schools of medicine and teaching hospitals to provide comprehensive **health care and services for children of school age, or for preschool children,** particularly in areas with concentrations of low-income families, including medical and dental screening, diagnosis, and preventive services for all children in the areas; and treatment, correction of defects, and aftercare, including dental care, for children of low-income families who would not otherwise receive such care; and appropriations for the program up to $15 million for fiscal year 1966, $35 million for 1967, $40 million for 1968, $45 million for 1969, and $50 million for 1970.

• A new program of **grants to institutions of higher learning for training professional personnel,** such as physicians, psychologists, nurses, dentists, and social workers, for work with crippled children, particularly mentally retarded children and those with multiple handicaps.

• Appropriations for the new training program up to $5 million for fiscal year 1967; $10 million for 1968; and $17.5 million for each fiscal year thereafter.

• **Increased appropriations for** grants to the States for (1) **maternal and child health services,** (2) **crippled children's services,** and (3) **child welfare services:** in *each* program up to $45 million for fiscal year 1966; $50 million for 1967; $55 million each for 1968 and 1969; and $60 million for succeeding fiscal years. After June 30, 1966, a satisfactory showing of progressive extension of maternal and child health services and crippled children's services is required in the States, with a view to making these services available by July 1, 1975, to children in all parts of the State. A previous provision in the Act, earmarking child welfare services funds for day-care services, is no longer effective after January 1, 1966.

• **Increases** in the Federal share of public assistance payments, amounting, in the program of **aid to families with dependent children** (AFDC), to an average of $1.25 per person a month; and exemptions in determining need for assistance of children's earnings up to $50 a child (not to exceed $150 per family) and of $5 per recipient of any other income.

• **A unified and expanded program of medical assistance** to provide the same quantity and quality of medical assistance for dependent children and their families as to other recipients of public assistance, and, if the States elect, to any medically indigent child in need of medical care, as well as to adults who, while they do not meet the State's definition of financial need, are otherwise eligible for public assistance and cannot meet medical expenses.

## *The Anti-Poverty War*

During the past summer, an increasing number of children and youth took part in programs established under the Economic Opportunity Act. (See CHILDREN, September–October 1964, p. 198, and March–April 1965, p. 81.) For example:

***Project Head Start*** enrolled more than 550,000 preschool children from low-income families in centers in 2,400 urban and rural communities for 8-week programs to prepare them for entry to kindergarten or the first grade this fall. Focusing on developmental activities and preschool learning experiences, the projects also provided health and social services.

In addition to the children's parents, who in many instances were involved in the centers as teachers' aides, assistants in program planning, or workers in a variety of nonprofessional jobs, some 45,000 people living in the neighborhoods of centers worked in them as "neighborhood residents."

Seventy percent of the Head Start programs were sponsored by local boards of education, the rest by private nonprofit groups, church groups, or community action programs functioning under the Economic Opportunity Act.

To provide special training for Project Head Start teachers, the National University Extension Association provided a series of 6-day training conferences on the campuses of 117 universities and colleges throughout the country. Some 35,000 teachers attended.

***The Job Corps*** included over 10,000 young men and women from 16 through 21 in 48 Job Corps centers around the Nation as of the end of July. They were receiving basic and vocational instruction in 36 conservation centers, operated by the U.S. Departments of Agriculture and of the Interior, and in 7 urban centers for men and 5 for women, operated under contract by universities, business firms, and State agencies.

In addition, 54 more conservation centers and 10 more urban centers for men and 15 for women are scheduled to be in operation by July 1, 1966.

In the men's urban training centers, enrollees were being provided with training in such occupations as auto and appliance repair, small boat repair, cooking, retail sales, office work, and building maintenance. Enrollees in the women's centers were being taught clerical work, retail sales, cooking, household services, graphic arts, electronics, and child care.

A special corporation called Women in Community Service (WICS), formed by a group of religious and women's organizations, is recruiting and screening young women for these centers.

***Neighborhood Youth Corps,*** as of July 30, included 346 individual projects providing jobs to 160,000 youths—in every State, the District of Columbia, and Puerto Rico; and in addition, 388 special summer projects, providing jobs for 125,000 young men and women.

***VISTA volunteers,*** as of July 30, included 250 persons, ranging in age from 18 to 80, who were working in 59 anti-poverty programs in 27 States; and 800 others who were being prepared in 19

training programs to take over assignments in mid-August in nearly 100 local programs in 40 States. The assignments range from organizing and operating preschool and day-care centers for underprivileged children to helping communities and neighborhoods organize self-help programs. VISTA volunteers serve for 1 year on a subsistence allowance, and receive, on retirement from the program, an amount equivalent to $50 for each month of service.

Under *the college work-study program,* as of the end of July, 38,500 students from low-income families were working on part-time or full-time jobs at a basic wage of $1.25 an hour.

During the fiscal year ending June 30, 1965, the Welfare Administration approved 164 *work-experience and training projects* in 43 States, the District of Columbia, Puerto Rico, and the Virgin Islands, to improve the employability of approximately 88,000 persons with some 276,000 dependents, most of them children. By the end of July, about 21,000 persons had been enrolled.

The projects are training people as nurses' aides, hospital orderlies, child-care aides, maintenance workers in buildings and parks, and other occupations. All projects offer counseling, social service, medical care, and day care for children as needed.

## *Adoption*

Findings related to the incidence of adopted children in caseloads of psychiatric clinics are contained in a recent study published by the Child Welfare League of America, "Behavioral Characteristics of Children Known to Psychiatric Outpatient Clinics," by Edgar F. Borgatta and David Fanshel. The study gives special attention to adoption status, sex, and age groupings.

The data are based upon information supplied by 30 agencies, geographically distributed, each having a minimum of a half-time social worker and a half-time psychiatrist or psychologist, and 607 cases were analyzed. In reference to some of the findings relating to adoption, the authors say:

"In summary, our study indicates that a higher agency arrival rate does exist for adopted children than might be expected for the general child population. The rate is possibly double, and certainly not as extraordinarily excessive as was originally suggested by Schechter. If even relatively simple things, such as the selective factors of race, social class, and prior contact with agencies are taken into account, the apparent difference becomes of questionable significance."

The authors point out that, although findings with regard to severity of problems treated were not clearcut, they ran *contrary* to the notion that adopted children have more serious problems than nonadopted children, and favored the interpretation that adoptive parents tend to consult agencies when they see trouble ahead rather than after it has arrived—perhaps because they are adoptive parents, because they are familiar with agency help, or because on the whole they are in relatively high educational and occupational status.

The authors also point out that the findings cannot be generalized to all adopted, as compared with all nonadopted, children; but that they do indicate once again that—when proper statistical controls are exercised—no solid support has been found so far for claims that adopted children are excessively prone to psychiatric problems.

## *Child Welfare Research*

The function, planning, and conduct of demonstration projects in child welfare were the subjects of discussion at a 3-day workshop held at the University of Chicago last May, under the sponsorship of the university's School of Social Service Administration. Part of a project on evaluative designs in child welfare being carried on by the school with the support of the Children's Bureau, the workshop was attended by personnel from Federal granting agencies—including the Children's Bureau, the Welfare Administration, and the Office of Education—recipients of child welfare research grants, and consultants with experience in conducting child welfare demonstrations.

The conferees agreed that the primary function of a demonstration is the testing of feasibility and that any additional research aims included should be subordinated to this purpose. They stressed the importance of a pilot, or developmental, phase to a sound project. They also agreed that the results of every demonstration project should be disseminated to the child welfare field; that the attention of the field should be called to negative results; and that replication, with appropriate modification under new conditions, is important in the accumulation of experience.

. . .

Eleven new child welfare research and demonstration grants totaling $672,605 were awarded by the Children's Bureau between January 1 and July 1, 1965, along with $1,581,251 for the continuance of ongoing child welfare research or demonstration projects. Of the new grants, three were concerned with child abuse and neglect. They went to:

- The Juvenile Protective Association of Chicago, $97,120, to demonstrate the effectiveness of an integrated approach in the provision of the varied services needed by families in which children are abused or neglected.
- The School of Social Work, University of Pennsylvania, $57,494, for a followup study of families which received intensive casework services from a protective agency.
- The School of Social Welfare, University of California, Berkeley, $49,572, to initiate a series of studies of services offered by public welfare departments and other community resources on behalf of abused or neglected children.

Other new grants were awarded to:

- The District of Columbia Department of Public Welfare, $115,066, for an expansion of services within its child welfare division to meet and prevent family crises.
- The Iowa Children's Home Society, Des Moines, $74,193, to demonstrate a deliberate effort to reach unmarried pregnant teenage girls in rural areas with intensive services designed to help them achieve a constructive plan for the future.
- The American Humane Association, Denver, $72,185, for a program to protect child victims of adult crimes from serious emotional damage.
- The Retarded Infants Services, Inc., New York, $69,761, to conduct a 3-year project to test the feasibility of training and using unskilled personnel as aides to professionals in caring for retarded children.
- Western Reserve University, Cleveland, $39,046, for designing long-range research into the economics and organization of social welfare programs to find ways of analyzing "returns" in relation to "investments," criteria for evaluative studies, and means of trans-

lating the fruits of high-cost demonstrations to realistic large-scale application.

• The Children's Bureau of Delaware, $38,730, for a study of adoption practices to determine factors predictive of success and of future crises.

• The University of Chicago, $34,964, to explore the feasibility of establishing a center at the university to carry out child welfare research, demonstrations, and training.

• The University of Georgia, Athens, $24,474, to develop a research program to determine effective processes for providing services in behalf of neglected children of low socioeconomic background in isolated rural areas.

## *Against Delinquency*

Seven Federal grants were awarded between March and June of this year by the Office of Juvenile Delinquency and Youth Development in cooperation with the President's Committee on Juvenile Delinquency and Youth Crime. They included three *training grants* which went to:

• The National Council of Juvenile Court Judges, Chicago, $18,898, to design and carry out a 2-week training institute, presented by an interdisciplinary faculty, for about 30 new juvenile court judges from courts serving rural and small urban areas, to serve as a model for universities and training centers in providing training opportunities for juvenile court judges.

• The Boston University Training Center in Youth Development, $42,963, for a series of short-term workshops and institutes for probation officers, parole officers, public welfare personnel, and education counselors, to be carried out in cooperation with the appropriate State and local authorities.

• The Council on Social Work Education, New York, $116,456, to design a comprehensive curriculum to prepare social workers for professional roles in community planning and action programs, to be based on a systemization of theoretical and research materials and on field studies of community organization practice, with the focus on professional intervention to achieve amelioration of social problems.

The other four grants, all *demonstration grants*, went to:

• The Hampton Beach Chamber of Commerce, Hampton, N.H., $41,870, for a study by the Chamber's Teenage Relations Subcommittee of the psychosocioeconomic antecedents of youth riots at beach resorts, the development of strategies to control youth behavior at Hampton Beach during the 1965 Labor Day weekend, and the issuance of reports useful to other communities.

• Rutgers University, New Brunswick, N.J., $89,732, for a program designed to help educationally disadvantaged children achieve social, emotional, and educational successes ordinarily not within the level of their expectations, through the provision of athletic, recreational, and vocational-experience programs; field trips; film-viewing; "book exposure;" lectures; tutoring (including tutoring of younger children by project participants).

• The Southern Arizona Mental Health Center, Tucson, $63,659, for a program for early intervention in cases of identified potential delinquents and school dropouts in a sparsely populated, multi-ethnic area, through the use of significant individuals in the children's environment and nonprofessional, but specially trained, "mediators," and the operation of a motivation-and-skill training unit after school and on Saturdays, to help underachievers to improve their academic skills.

• The Active Community Team, Detroit, $148,920, for the provision of a community intervention team at police precinct level, composed of professional, semiprofessional, and nonprofessional staff members, to which law violators 14 to 16 years old can be referred at time of police decision, and which will work within the neighborhood to provide these identified delinquents with appropriate service and opportunities.

## *UNICEF*

The subject of family planning as a possible field for UNICEF (United Nations Children's Fund) was discussed for the first time by the agency's Executive Board at its June 1965 meeting in New York.

The U.S. delegation brought up the subject, placing it within the context of good maternal and child health services, and suggested that UNICEF's role might be that of training maternal and child health personnel in this field. The Board agreed to place the subject on the agenda for its next session and requested the agency's director to prepare a report on the scope and content of a proposed family planning program, after consultation with the World Health Organization. The Board further requested that several family planning projects be brought to it for study from countries giving such aid a high priority in their requests to the agency.

The overall theme for the June meeting was "Reaching the Young Child." Papers and statements presented by both developed and developing countries indicated that the child from 1 to 6 is both neglected and hard to reach. No new UNICEF program was proposed, but the consensus of the meeting was that much greater effort could, and should, be made in all programs—health, nutrition, education, social services—to see that the needs of children in this vulnerable group are more fully met.

During the session, the Board committed nearly $30 million to 200 projects in the fields of health services, disease control, nutrition, family and child welfare, education, and vocational training. The greatest increase was in aid to education, especially in Africa.

This meeting was the first under the leadership of Henry Labouisse, who became the organization's executive director following the recent death of the former director, Maurice Pate.

At the Board's next meeting, scheduled for May 1966 in Addis Ababa, Ethiopia, the needs of the African child will receive special attention.

## *Maternity Care*

An "immediate, substantial, and concerted multidisciplinary attack on maternity care manpower shortages" is urgently needed, according to the findings of a study of the manpower situation in maternity care recently conducted by the Children's Bureau at the request of the Special Assistant to the President for Mental Retardation. In the study, the Bureau's Division of Research reviewed data on present and future needs for maternity care against the supply of health manpower in general and maternity care manpower in particular. The results suggest increasingly widened gaps between the need for and availability of the variety of health personnel used in maternity care.

Noting that today the infant mortality rate in the United States compares unfavorably with the rates in nine other countries and that, within this country, wide geographic variations exist in both

infant and maternal mortality—with a tendency toward higher rates in rural areas and in the cores of large cities—the study related these differences to deficiencies in maternity care manpower in such areas. The improvement of present services and the provision of future services required by an increasing population of women of childbearing age, it found, will require:

- analysis of contemporary concepts of high-quality maternity care into its indispensable components;
- determination of which tasks might be assigned to auxiliary personnel of (a) types now in existence and (b) types which might be developed;
- development of fresh and effective service patterns to replace stereotypes of operation, in order to enhance quality of care and bring about more efficient use of manpower.

A chart book presenting the data and findings of the study will be published by the Bureau in the near future.

## *Rubella*

By mid-July, 44 States had responded to requests from the Children's Bureau for information about the effects of the nationwide rubella epidemic which began in the East in the winter and spring of 1963–64, and spread to the South and finally to the Far West in 1964–65—the worst epidemic of this disease in the United States in two decades.

The survey was initiated by the Bureau in the spring of 1965 to determine the ability of the States to meet the needs of children adversely affected before birth because their mothers had contracted rubella while pregnant. According to an estimate of Dr. Richard Masland, Director of the National Institute of Neurological Diseases and Blindness, the epidemic resulted in "at least 4,000 defective babies born to the 2 million pregnant women then at risk."

Rubella, when contracted by the mother in early pregnancy, may result in such malformations in the offspring as hearing impairment, cataracts, anomalies of the heart, microcephaly, and mental retardation. The infant may also be born with active rubella infection and be the source of secondary cases of the disease.

Reports from the survey thus far indicate that a number of State health departments have instituted procedures to follow up the children born of rubella-infected mothers. For example, the Kansas department, having from birth certificates a lead on rubella-connected disability, has instituted a followup study. California has appointed a full-time physician to follow up the cases of women who had rubella in early pregnancy. Other State health departments have alerted physicians or local health departments to watch for rubella-damaged infants. A number of medical centers are conducting special studies, by multidisciplinary teams, in the evaluation of rubella-damaged infants.

* * *

The Baylor University College of Medicine, Houston, Tex., has been granted $70,344 by the Children's Bureau to maintain, for a 1-year period, a clinic for the multidisciplinary study and treatment of infants infected with rubella.

* * *

Public Health Service and industry scientists have recently developed a simple and rapid test for rubella, which provides identification of antibodies to this infection within 24 hours, as compared with the 2 weeks required for previous methods. Through use of the new test, the Public Health Service reports, timely reconnaissance can be made of any future rubella epidemics.

* * *

The Committee on Control of Infectious Diseases of the American Academy of Pediatrics recently issued a recommendation that "infants born with clinical features characteristic of intrauterine rubella infection be managed with the same isolation precautions employed for patients with rubella."

## *Health Research*

In the first half of this calendar year, the Children's Bureau made 33 grants, totaling $1,708,512, for new research projects in maternal and child health and crippled children's services, and 11 grants, totaling $954,060, to continue projects already under way.

Included in the new projects are a number concerned with the reduction of premature births and maternal and infant deaths, reaching low-income groups with high-quality maternity and pediatric care, casefinding of children with potentially handicapping conditions, the efficacy of various treatment methods for handicapping conditions in children, and the reorganization of services to effect more efficient use of personnel and better quality of care.

Some of the award recipients were:

- The Johns Hopkins University School of Medicine, $187,786, for the promotion and study of effective utilization of nonprofessional personnel in mental retardation centers.
- State University of New York, Downstate Medical Center, Brooklyn, $91,066, to train and evaluate the use of "health visitors" recruited from disadvantaged neighborhoods to work in a housing project, a public school, a local union shop, and a small neighborhood.
- Harvard Medical School, $107,795, to study the effects of providing comprehensive pediatric care to low-income families and children.
- California State Department of Public Health, $72,275, for a study of children receiving treatment for congenital heart disease.
- The University of North Carolina, $69,750, for a demonstration and research program in health needs and health care of children in a day-care center.
- The University of Chicago, $21,414, for a controlled 10-year followup study of small (under 1,500 grams) premature babies.

## *Services for Health*

As of mid-July, the Public Health Service had signed a contract with every State except Ohio and North Carolina, and with the District of Columbia and Puerto Rico, for counseling and referral services for Armed Forces medical rejectees, involving $4,048,929 in Federal funds. The program began with three pilot projects established in New York City, Philadelphia, and Denver in 1962 following study and suggestions of a subcommittee of the Interdepartmental Committee on Children and Youth. (See CHILDREN, January–February 1962, p. 35, and January–February 1964, p. 34–35.)

Under the contract, a designated State agency will screen and evaluate Armed Forces examination station medical records of men rejected for military service for medical reasons; counsel the rejectees concerning their health needs; and refer them to health and rehabilitation resources for appropriate services.

The Vocational Rehabilitation Administration is collaborating with the PHS in the review and approval of implementation plans submitted by the States.

# IN THE JOURNALS

## *Young Marriages*

With the "long-term trend toward younger ages at marriage in the United States . . . now apparently arrested," programs to help youth "avoid injudicious marriage decisions" should concentrate on the development of the personalities, interests, and potentials of youth, rather than focus on the risks of youthful marriage, advises Lee G. Burchinal of the U.S. Office of Education, in the May 1965 issue of the quarterly *Journal of Marriage and the Family*. ("Trends and Prospects for Young Marriages in the United States.")

Defining "young marriage," as marriages involving at least one partner under 19, Dr. Burchinal reviews census data on the extent of such marriages from 1910 through 1960, and discusses some of the social factors which may be responsible for the stability of the trend since 1950.

He also discusses the meaning of data showing higher divorce and separation rates in younger marriages, as contrasted with marriages of persons in their twenties, warning that age is an adequate criterion for predicting marital risk only when accompanied by negative personality characteristics and interpersonal skills. Premarital pregnancy he names as probably the "single most compelling factor" leading to the erosion of young marriages, other significant factors being low-status background, limited education, meager economic basis, and the need for continued parental support.

Among the author's suggestions for reducing young marriage rates are: greatly increased educational, conseling, and social services; and the provision of "attractive alternate roles" for youth, through increased educational, service, and job opportunities.

## *"Project Books"*

The Crawford County (Iowa) Department of Social Welfare's additional service of presenting books as gifts to children of underprivileged families in its caseload has "enabled us to establish wonderful relationships with the children," and "vividly illustrates to the parents . . . that we consider books important . . . as we do diet, health, or housing," says Dorothy B. Ferrell in the Spring 1965 issue of *Iowa Public Welfare in Action*. ("Books for Preschoolers.")

The author, a public welfare worker, uses brief case stories to describe the results of a project begun in November 1964, when a local business and professional women's club set up a fund for purchasing books to be given to the county's underprivileged children through its social welfare department. Later, other organizations joined in, reports the author, and collected used books for both preschool and older children, and the school library contributed women's magazines for distribution to the children's mothers.

## *Mental and Motor Test Scores*

According to Nancy Bayley, writing in the June 1965 issue of *Child Development*, there is ample evidence that, within normal limits, developmental status in the first year of life is a poor predictor of later mental and motor functioning—and there is also ample evidence that mental test scores after 3 or 4 years of age bear a relationship to a number of indicators of socioeconomic status. ("Comparisons of Mental and Motor Test Scores for Ages 1–15 Months by Sex, Birth Order, Race, Geographical Location, and Education of Parents.")

The author, noting that the period between 1 and 4 years of age is important in the development of mental and motor functions, recommends that this age period be studied closely in efforts to seek out those environmental factors which are relevant to the development of intellect and of behavior seemingly resistant to environmental impacts; and to identify the behavior and the specific age periods for which correlation between test scores and socioeconomic ratings first occur. She also stresses the need for careful study of the development of mental processes in the second year of life, as "within this period evidently will be found the explanation of the socioeconomic and ethnic differences in mental functioning that are repeatedly found for children of 4 years and older."

The author arrived at these conclusions after evaluation of tests in which revised forms of Bayley's scales of mental and motor development were administered to 1,409 infants, ages 1–15 months. The babies were drawn primarily from hospital well-baby clinics. No differences were found between Negro and white babies on the mental scale, but the Negro babies tended, consistently, to score above the white babies on the motor scale. The author suggests that the advantage the Negro babies have in motor development "may lie" in a generally heightened muscle tone.

## *Gang Control Controversy*

Malcolm K. Klein, of the Youth Studies Center, University of Southern California, in the June 1965 issue of the quarterly *The Social Service Review*, discusses some of the major differences in assumptions held by the police and social agencies in New York City and Los Angeles which have led to controversies over the social agencies' use of "detached workers" in an effort to change the behavior of juvenile street gangs. ("Juvenile Gangs, Police, and Detached Workers: Controversies About Intervention.")

In these cities, detached worker programs were temporarily interrupted when the police charged that they created more trouble than they prevented. While in both instances the programs were continued under social agency-police agreement, the author points out that the agreements were "not . . . marked by any total resolution of value differences—nor should one expect such total resolution" when "two agencies can look at one set of data" and, drawing "diametrically opposite findings," argue less over the facts involved than over "philosophies of gang intervention."

Genuine resolution, the author suggests, requires empirical studies of the questions around which the controversies revolve, and he presents areas for inquiry under six (but "by no means all") of these questions:

Do "sponsored" gangs create more

trouble than "unsponsored" gangs? Does supervision of gangs lead to increased status? Does supervision lead to greater cohesion within the gang? Is gang leadership psychopathic? Are truce meetings between rival gangs helpful or harmful? Do gang workers increase anti-police feelings among gang members?

The author recommends that law enforcement officials and social work administrators come together and consider dispassionately data that "are helpful in understanding the nature of the differences and in resolving the problems."

### *New Journal*

Publication of a new quarterly, *The Journal of Applied Behavioral Science*, was begun in March by the National Training Laboratories of the National Education Association, with the stated purpose of seeking "to improve communication between research workers in . . . anthropology, economics, political science, psychiatry, psychology, or sociology, and leaders in groups, organizations, and communities." The journal, according to its editor, Goodwin Watson, will focus on the processes by which individuals and institutions are changed, improvement of the research done in the behavioral sciences and facilitation of its application by influential practitioners.

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# READERS' EXCHANGE

**BREWSTER:** *Lessons for today*

Berta M. Brewster's article, "Extending the Range of Child Welfare Services" [CHILDREN, July–August 1965], reaffirms the thesis that with careful planning, sufficient competent staff, and coordination of resources, social services to children and their families can materially strengthen family life, reduce the need for foster care, and, even though expensive, provide the most economical means of salvaging young lives.

My concern is not with Miss Brewster's article nor the validity of the lessons to be learned from the pilot project in Rensselaer County. My concern is that these lessons were not learned in the early forties rather than in the mid-sixties. The lessons we should be learning today are not how to extend the range of services on a demonstration basis but how to make these vital and necessary services available to all children in our respective jurisdictions; how to provide the best services possible with less than optimum professionally trained staff; and how to finance and staff services statewide, reaching children in the most rural and professionally starved sections of the State, as well as those in the more urban and professionally stimulating environments.

In Mississippi, we have chosen the difficult approach of accepting responsibility for providing the full range of child welfare services statewide, realizing that the quality of service depends on the availability of staff and the competence of the staff serving children.

We, too, have learned many lessons. For one thing, children and families with serious child welfare problems live in every county of the State. As services become known in a community and the county department of public welfare is recognized as an agency responsible for protecting children and family life, referrals multiply and caseloads grow. We have found that even with an extensive program of educational leave it is not possible to retain staff in sufficient numbers to do more than maintain a status quo on geographic coverage with trained staff. We have found that agency-trained staff can attain an amazing degree of competence, if carefully selected and given the opportunity to develop under a supervisor trained and experienced in child welfare.

As a result of the lessons we have learned from our inability to extend quality service county by county, we are moving into a plan of trying to provide service on an area basis. An area office serves two or more counties and is staffed by a child welfare supervisor, at least one child welfare worker with professional training, and several agency-trained workers. From this plan we will gain experience in the differential use of staff, in identifying the situations in which agency-trained staff, with close supervision, can meet the needs of children. We will determine whether a worker, based in an adjoining county, can maintain a relationship with a child and his family which will enable him to diagnose problems and to be available when he is needed. We will evaluate the "holding power" of a group situation where the workers have common goals, problems, and a sense of being a part of a team working toward the same objectives. We will find out whether the problems of coordination of area services with the other services for children in the local community are insurmountable—or whether they can be worked out, with each component of service gaining in strength.

*Sara R. Caldwell*
*Director, Division of Child Welfare, Mississippi State Department of Public Welfare*

***Colorado's way***

The article by Berta M. Brewster is timely in pointing out the need for a variety of services to meet the needs of parents and children. The 1962 Public Welfare Amendments to the Social Security Act have made it necessary for all of us to scrutinize our program carefully to determine where primary emphasis should be placed.

Colorado, with a State-supervised, county-administered child welfare program, provides services to children in their own homes, including protective services. Some homemaker service has been provided since 1937, but so far in only 12 counties. Today, these have a total of 36 homemakers. Last year, 796 children were legally freed for adoption, their custody being given to county departments of public welfare with right to consent to adoption; and 725 children were placed in adoptive homes.

In this State we have long recognized the need for establishing a day-care program for children of working mothers, but now are seeing other uses for day care. In Colorado Springs, the county (El Paso) has established a center for children in the program of aid to families with dependent chil-

dren, who are referred because of neglect or abuse. Both children and mothers attend the center. While the children are engaged in planned activities, the mothers are taught how to be better mothers and homemakers.

In one of our rural, mountainous counties where a Catholic church donated space for a day-care center for culturally deprived children, numerous volunteers turned out to put the center in shape—a plumber to fix the toilets, others to cover the pipes with asbestos, to clean, and to paint. Tables and chairs were donated.

The 23 counties in Colorado having 91 percent of the State's population have 92 percent of the child welfare cases. However, we still have some rural counties in which there are no child welfare workers. In order to provide services to children in these counties, we plan to develop child welfare districts in which two or more counties will share a child welfare worker or workers. Salaries of these workers will be reimbursed by the State on 100-percent basis during the first year.

As of September 1965, there will be 45 public welfare staff on educational leave. Of this number, 17 will be going into child welfare.

*Marie C. Smith*
*Director, Division of Children and Youth, Colorado State Department of Public Welfare, Denver*

GLASSER AND NAVARRE: *AFDC-connected problems*

Aid to families with dependent children, our most significant program in its potential for strengthening family life, is at the same time the most maligned and misunderstood of the public assistance categories. Paul H. Glasser and Elizabeth L. Navarre, in the July-August 1965 issue of CHILDREN, emphasize the universal problem for all persons of low socioeconomic status and tell how this is heightened and intensified for the person living on a minimal AFDC grant. ["The Problems of Families in the AFDC Program."] More important, the study shows that the economic problems are compounded and aggravated by societal attitudes toward persons receiving AFDC. What emerges, then, is that all persons living in poverty have many complex problems, and when two additional factors are added—the least amount of money and the attitude of our society because of the source of the funds—an unbearable burden is created for the families receiving AFDC. Added to this is the contradiction within society itself, in terms of what it expects of a woman who is the head of a family and how this further complicates the situation for the woman who must receive money from public funds.

All agencies which administer the AFDC program have ample evidence of how lonely these mothers are—how poignantly they feel society's attitude toward them and how this tends to alienate them from community living. In the administration of the program, they are referred to all too frequently as "AFDC mothers" or "mothers of AFDC children." Thus these mothers find that they are not only unwanted by society, but too often they feel that the agency, too, is not concerned.

Many communities provide special services to one-parent families created by death, divorce, or illness. All too often, however, these are not available for, nor do they accept, the lone parent trying to raise a family on an AFDC grant.

What illuminates this article is an empathy for the mother of the AFDC family, expressed in clear, uncomplicated, almost poetic language, indicative of the respect and warm regard the authors feel for these mothers. How essential this is, if they are to be helped to mobilize their own strengths and resources!

*Esther Lazarus*
*Director, Baltimore Department of Public Welfare, Maryland*

POVERTY: *Material wanted*

A group of graduate students of the School of Social Work at the University of Toronto are planning, as part of their research project, a review of the North American literature on *poverty*.

We would like to enlist the help of professional colleagues in requesting copies of articles, speeches, pamphlets, booklets, unpublished papers, and other pertinent material dealing with all aspects of poverty in North America.

We hope eventually to publish an inventory of the literature on poverty, which will be helpful to many professional and nonprofessional sources. Please send copies of the available literature to the undersigned at the School of Social Work, University of Toronto, 273 Bloor Street West, Toronto 5, Canada. Your cooperation is appreciated.

*Benjamin Schlesinger*
*Assistant Professor, School of Social Work, University of Toronto*

FANSHEL: *More on* Shared Fate

I have been interested in following the dialogue between David Fanshel and Arthur Glickman around Dr. Fanshel's review of David Kirk's "Shared Fate." [CHILDREN, September–October 1964, pp. 193–196; "Readers' Exchange," March–April 1965, pp. 87–88.] If the issue is still open, I would like to make the dialogue a trialogue.

Personally, I welcomed Dr. Kirk's book not only for its own sake but because there are so few recent substantial studies into the nature of the adoption process. Moreover, it seems to me that in reporting on his research Dr. Kirk has gone beyond the technical. He has contributed the results of a long-overlooked ratiocinative process which needs to be considered independently of the research method since it transcends any logical interpretation of experimental results.

Critical consideration of research ought to have an underlying philosophy which considers the process designed to test hypotheses separately from the kind of research designed to generate theory. I believe Dr. Fanshel was emphasizing the former; Dr. Kirk, the latter.

In the preparation of a competent research report, an important step is the attempt to view the data from a higher level of abstraction. No logical bridge exists between one level of abstraction and another. To take this step, a researcher must be more courageous and creative than in some other aspects of the reporting process.

My plea, then, is for an expanded style of research evaluation. Of course, technical considerations should not be abandoned. But they should not become the totality of the reviewer's realm of operation. This should also include consideration of existing knowledge in the area being explored, the nature of the hypothesis-generating function of research, the translation into successive levels of abstraction, and, most important, creative insight.

*Audrey Rawitscher*
*Doctoral Student, School of Social Work, University of Southern California, Los Angeles*



U.S. GOVERNMENT PRINTING OFFICE: 1965

## SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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A SELECTED BIBLIOGRAPHY ON DAY CARE SERVICES. Alice H. Merriam. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 94 pp. Single copies available from the Bureau without charge.

The listings in this bibliography are presented in 16 categories including such subjects as administration, program, the parent, meeting special needs, planning and legislation, licensing and standards, research, and day care in other countries.

GRANTS-IN-AID AND OTHER FINANCIAL ASSISTANCE PROGRAMS ADMINISTERED BY THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. 1964–65 Edition. Department of Health, Education, and Welfare, Office of the Assistant Secretary (for Legislation), Office of Program Analysis. 1965. 345 pp. plus fold-in tables. $2.50.

This report provides facts on the backgrounds, purposes, financial aspects, application procedures, program developments, and legal basis of the 112 financial assistance programs under the Department of Health, Education, and Welfare. It contains detailed information on the formulas used in distributing funds, State matching requirements, and figures on funds allocated under each program.

COMPILATION OF THE SOCIAL SECURITY LAWS, INCLUDING THE SOCIAL SECURITY ACT, AS AMENDED, AND RELATED ENACTMENTS THROUGH DECEMBER 31, 1964. Compiled by the Department of Health, Education, and Welfare, Social Security Administration. House of Representatives Document No. 373 (88th Cong. 2d sess.). 1964. 677 pp. $2 (paper cover).

In addition to the entire Social Security Act, as amended, the book includes sections entitled "Sections of Amending Acts Having Current Effect on the Social Security Act;" "Superseded Provisions of the Social Security Act;" "Provisions of the Internal Revenue Code of 1954;" and "Selected Provisions of Other Laws Relating to the Social Security Act." Among the latter are sections of the act of 1912 creating the Children's Bureau, the Area Redevelopment Act of 1961, the Civil Rights Act of 1964, the Manpower Development and Training Act of 1962, and the Peace Corps Act.

HEALTH SERVICES FOR UNMARRIED MOTHERS. Elizabeth Herzog and Rose Bernstein. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 425. 1964. 61 pp. 25 cents.

Reviews studies relating to complications of pregnancy in unmarried mothers; availability, use, and quality of medical services available to them; and experiments to bring them coordinated medical and social services. The strengths and weaknesses of the studies and the generalizations derived from them are evaluated, and areas for future studies suggested.

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